TEXAS REGISTER

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Felicia Mora
10th Grade

School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

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IN THIS ISSUE

ADOPTED RULES

Open Meetings

Statewide agencies and regional agencies that extend into four or more counties post meeting notices with the Secretary of State.

Meeting agendas are available on the *Texas Register*'s Internet site:
http://www.sos.state.tx.us/open/index.shtml

Members of the public also may view these notices during regular office hours from a computer terminal in the lobby of the James Earl Rudder Building, 1019 Brazos (corner of 11th Street and Brazos) Austin, Texas. To request a copy by telephone, please call 512-463-5561. Or request a copy by email: register@sos.state.tx.us

For items ***not*** available here, contact the agency directly. Items not found here:

- minutes of meetings
- agendas for local government bodies and regional agencies that extend into fewer than four counties
- legislative meetings not subject to the open meetings law

The Office of the Attorney General offers information about the open meetings law, including Frequently Asked Questions, the *Open Meetings Act Handbook*, and Open Meetings Opinions.
http://www.oag.state.tx.us/opinopen/opengovt.shtml

The Attorney General's Open Government Hotline is 512-478-OPEN (478-6736) or toll-free at (877) OPEN TEX (673-6839).

Additional information about state government may be found here:
http://www.state.tx.us/

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Meeting Accessibility. Under the Americans with Disabilities Act, an individual with a disability must have equal opportunity for effective communication and participation in public meetings. Upon request, agencies must provide auxiliary aids and services, such as interpreters for the deaf and hearing impaired, readers, large print or Braille documents. In determining type of auxiliary aid or service, agencies must give primary consideration to the individual's request. Those requesting auxiliary aids or services should notify the contact person listed on the meeting notice several days before the meeting by mail, telephone, or RELAY Texas. TTY: 7-1-1.

THE GOVERNOR

As required by Government Code, §2002.011(4), the *Texas Register* publishes executive orders issued by the Governor of Texas. Appointments and proclamations are also published. Appointments are published in chronological order. Additional information on documents submitted for publication by the Governor's Office can be obtained by calling (512) 463-1828.

Appointments

Appointments for June 1, 2009

Appointed as the Student Representative for the Higher Education Coordinating Board, effective June 1, 2009, for a term to expire May 31, 2010, Heather A. Morris of Lubbock. Ms. Morris is replacing Charles Lewis of Houston whose term expired.

Appointed as the Student Regent for the University of North Texas, effective June 1, 2009, for a term to expire May 31, 2010, Jennifer Ozan of Fort Worth. Ms. Ozan is replacing Meghan Vittrup of Lewisville whose term expired.

Appointed as the Student Regent for Texas Tech University System, effective June 1, 2009, for a term to expire May 31, 2010, Kyle R. Miller of Plainview. Mr. Miller is replacing Kelli Stumbo of Lubbock whose term expired.

Appointed as the Student Regent for Texas Woman's University, effective June 1, 2009, for a term to expire May 31, 2010, Rae Lynn McFarlin of Bonham. Ms. McFarlin is replacing Scarlett Pope of Grapevine whose term expired.

Appointed as the Student Regent for Texas State University System, effective June 1, 2009, for a term to expire May 31, 2010, William Clayton Patterson or Richardson. Mr. Patterson is replacing Nicole Lozano of Huntsville whose term expired.

Appointed as the Student Regent for the University of Texas System, effective June 1, 2009, for a term to expire May 31, 2010, Karim Meijer of Katy. Mr. Meijer is replacing Benjamin Dower of Austin whose term expired.

Appointed as the Student Regent for the Texas A&M University System, effective June 1, 2009, for a term to expire May 31, 2010, Hunter Bollman of Katy. Mr. Bollman is replacing Anthony Cullins of Commerce whose term expired.

Appointed as the Student Regent for Midwestern State University, effective June 1, 2009, for a term to expire May 31, 2010, Leonard Benton of Wichita Falls. Mr. Benton is replacing Haley Lain of Wichita Falls whose term expired.

Appointed as the Student Regent for Texas Southern University, effective June 1, 2009, for a term to expire May 31, 2010, Patrice A. McKenzie of Houston. Ms. McKenzie is replacing Kristopher Krishna of Houston whose term expired.

Appointed as the Student Regent for Stephen F. Austin State University, effective June 1, 2009, for a term to expire May 31, 2010, Morgan Tomberlain of Longview. Ms. Tomberlain is replacing Lacey Claver of Nacogdoches whose term expired.

Appointed as the Student Regent for the University of Houston, effective June 1, 2009, for a term to expire May 31, 2010, Kristen Lindley of Spring. Ms. Lindley is replacing Tamara K. Goodwin of Houston whose term expired.

Appointments for June 5, 2009

Appointed to the Parks and Wildlife Commission for a term to expire February 1, 2015, Dan Allen Hughes, Jr. of Beeville (replacing Rick Campbell of Center who resigned).

Rick Perry, Governor

TRD-200902290

♦ ♦ ♦

Proclamation 41-3185

I, RICK PERRY, Governor of the State of Texas, did issue an Emergency Disaster Proclamation on September 8, 2008, as Hurricane Ike posed a threat of imminent disaster along the Texas Coast and in specified counties in Texas. The disaster proclamation was subsequently renewed through June 4, 2009, in the wake of Hurricane Ike.

WHEREAS, Hurricane Ike struck the State of Texas on September 13, 2008, causing substantial destruction in South and East Texas.

WHEREAS, Hurricane Ike continues to create a state of disaster for the people in the State of Texas.

WHEREAS, the state of disaster includes the counties of Chambers, Galveston, Jefferson, and Orange.

THEREFORE, in accordance with the authority vested in me by Section 418.014 of the Texas Government Code, I do hereby renew the disaster proclamation and direct that all necessary measures, both public and private, as authorized under Section 418.017 of the code, be implemented to meet that disaster.

As provided in Section 418.016 of the code, all rules and regulations that may inhibit or prevent prompt response to this threat are suspended for the duration of the incident.

The renewal of the disaster proclamation becomes effective on June 5, 2009, and shall remain in effect until July 4, 2009, unless renewed or terminated.

In accordance with the statutory requirements, copies of this proclamation shall be filed with the applicable authorities.

IN TESTIMONY WHEREOF, I have hereunto signed my name and have officially caused the Seal of State to be affixed at my Office in the City of Austin, Texas, this the 4th day of June, 2009.

Rick Perry, Governor

Attested by: Esperanza "Hope" Andrade, Secretary of State

TRD-200902314

♦ ♦ ♦

THE ATTORNEY GENERAL

The *Texas Register* publishes summaries of the following: Requests for Opinions, Opinions, Open Records Decisions.

An index to the full text of these documents is available from the Attorney General's Internet site http://www.oag.state.tx.us. Telephone: 512-936-1730. For information about pending requests for opinions, telephone 512-463-2110.

An Attorney General Opinion is a written interpretation of existing law. The Attorney General writes opinions as part of his responsibility to act as legal counsel for the State of Texas. Opinions are written only at the request of certain state officials. The Texas Government Code indicates to whom the Attorney General may provide a legal opinion. He may not write legal opinions for private individuals or for any officials other than those specified by statute. (Listing of authorized requestors: http://www.oag.state.tx.us/opinopen/opinhome.shtml.)

Request for Opinions

RQ-0800-GA

Requestor:

The Honorable Scott Brumley

Potter County Attorney

500 South Fillmore Street, Room 303

Amarillo, Texas 79101

Re: Whether a county auditor may require the county treasurer to obtain prior approval of a transfer of county funds from one account in the county depository to another, or from one investment to another (RQ-0800-GA)

Briefs requested by July 3, 2009

RQ-0801-GA

Requestor:

The Honorable Steve Ogden

Chair, Committee on Finance

Texas State Senate

Post Office Box 12068

Austin, Texas 78711

The Honorable Jim Pitts

Chair, Committee on Appropriations

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Constitutionality of appropriation rider concerning one-time payment to eligible members of the Employees Retirement System and the Teacher Retirement System (RQ-0801-GA)

Briefs requested by July 6, 2009

RQ-0802-GA

Requestor:

Mr. Sidney "Buck" LaQuey

Grimes County Auditor

Post Office Box 510

Anderson, Texas 77830

Re: Whether a justice of the peace deferring the adjudication of a charge of violating the Parks and Wildlife Code may impose a special expense without assessing a fine and, if so, whether any portion of the special expense must be remitted to the Parks and Wildlife Department (RQ-0802-GA)

Briefs requested by July 9, 2009

For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.

TRD-200902319
Stacey Napier
Deputy Attorney General
Office of the Attorney General
Filed: June 10, 2009

♦ ♦ ♦

PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER J. PURCHASED HEALTH SERVICES

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §§355.8061, 355.8063, 355.8068

The Texas Health and Human Services Commission (HHSC) proposes to amend §355.8061, Payment for Hospital Services, and §355.8063, Reimbursement Methodology for Inpatient Hospital Services. HHSC proposes to add new §355.8068, Supplemental Payments to Certain Urban Hospitals, to consolidate and update the inpatient and outpatient supplemental payment rule language for eligible publicly-owned or -affiliated urban hospitals.

Background and Justification

HHSC is combining the Medicaid inpatient and outpatient hospital supplemental payment methodologies from existing rules into one new comprehensive rule that will fully describe supplemental payments made to eligible publicly-owned or -affiliated urban hospitals. HHSC is updating the language in the new rule to better explain the complex processes used in urban hospital supplemental payments.

The proposed new rule also expands the number of publicly-owned or -affiliated urban hospitals that are eligible to receive Medicaid supplemental payments. Currently, 11 hospitals already receive Medicaid supplemental payments. New §355.8068 makes six additional public hospitals in counties with populations greater than 100,000 eligible for these payments.

HHSC will not make supplemental payments to any new hospital eligible under this rule on or after September 1, 2009, until the State Plan Amendment has been approved by the Centers for Medicare and Medicaid Services (CMS).

Section-by-Section Summary

The language in §355.8061(a)(4) subparagraphs (A) and (E) relating to outpatient supplemental payments for eligible publicly-owned or -affiliated urban hospitals is deleted. New language is added to subparagraph (A) to direct the reader to new proposed §355.8068 for information on supplemental payments to these hospitals. Other changes are made to §355.8061 to update references and clarify rule language.

The language in §355.8063(t)(1), (2), and (3) relating to inpatient supplemental payments for eligible publicly-owned or -affiliated urban hospitals is deleted. New language is added to paragraph (1) to direct the reader to proposed new §355.8068 for information on supplemental payments to these hospitals. Other changes are made to §355.8063(t) to update references and clarify rule language.

Proposed §355.8068(a) states that Medicaid supplemental payments will be available for inpatient and outpatient services provided by eligible publicly-owned or -affiliated urban hospitals that serve high volumes of Medicaid and uninsured patients.

Proposed §355.8068(b) provides definitions for "Disproportionate Share Hospital (DSH)," "DSH Limit," "DSH Room," "DSH Reporting Period," "Medicaid Allowable Outpatient Hospital Costs," "Public Funds," and "Publicly-Owned or -Affiliated Hospital."

Proposed §355.8068(c) specifies the counties in which publicly-owned or -affiliated urban hospitals may be eligible for inpatient and outpatient supplemental payments. The list of counties is the same as the list that was previously in §355.8063(t)(1) and §355.8061(a)(4)(A) with the following changes. Public hospitals in three additional counties are added to the list: Brazoria, Fort Bend and Wichita counties. Randall County is removed from the list because the hospital that is affiliated with the Amarillo Hospital District is located in Potter County rather than Randall County, which is covered by the rule. Proposed §355.8068(c) also specifies that no more than two publicly-owned or -affiliated hospitals in each of the listed urban counties may be eligible for supplemental payments, compared to the limit of one hospital per county that previously was in §355.8063(t)(3).

Proposed §355.8068(d) lists the effective dates in which eligible hospitals in specific counties began receiving supplemental payments.

Proposed §355.8068(e) states that the source of state matching funds for the supplemental payments will be intergovernmental transfers.

Proposed §355.8068(f) identifies the fiscal restrictions on inpatient supplemental payments and reviews the methodology for calculating quarterly inpatient supplemental payments to DSH and non-DSH hospitals. This subsection also states that all supplemental payments are subject to reductions due to the aggregate Medicaid upper payment limits.

Proposed §355.8068(g) identifies the fiscal restrictions on outpatient supplemental payments and reviews the methodology for calculating quarterly outpatient supplemental payments to DSH and non-DSH hospitals. This section also states that all supplemental payments are subject to reductions due to the aggregate Medicaid upper payment limits.

Fiscal Note

Thomas M. Suehs, Deputy Executive Commissioner for Financial Services, has determined that during the first five-year period the proposed rules are in effect there will be no fiscal impact to state government as a result of adding new hospitals to the UPL program for publicly-owned or -affiliated urban hospitals because the non-federal share of these supplemental payments is derived from intergovernmental transfers. The addition of the six new hospitals described above to the urban hospital UPL program will have a neutral fiscal impact.

No net additional supplemental payments will be made to publicly-owned or -affiliated urban hospitals because these urban hospitals in Texas are currently being paid at the aggregate cap calculated in 2009 for urban and rural public hospitals. Instead, funds will be redistributed among all the participating hospitals. The existing qualified public hospitals may have their future funds reduced as a result of this redistribution. If the aggregate cap for public hospitals increases in FY 2010, public hospitals in the state may receive additional federal funds. Local governments will not incur additional costs.

Small and Micro-business Impact Analysis

Mr. Suehs has also determined that there will be no effect on small businesses or micro businesses to comply with the proposal, as they will not be required to alter their business practices as a result of the rules. There are no anticipated economic costs to persons who are required to comply with the proposed rules. There is no anticipated negative impact on local employment.

Public Benefit

Carolyn Pratt, Director of Rate Analysis, has determined that for each year of the first five years the proposed rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit, as a result of enforcing the rules, will be to allow the distribution of Medicaid supplemental payment funds to some of the smaller urban public hospitals that provide necessary Medicaid services. HHSC believes the public also will benefit from the consolidation of the inpatient and outpatient supplemental payment rules for publicly-owned or -affiliated urban hospitals into a single rule.

Regulatory Analysis

HHSC has determined that this proposal is not a "major environmental rule" as defined by §2001.0225 of the Texas Government Code. A "major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

Takings Impact Assessment

HHSC has determined that this proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under §2007.043 of the Government Code.

Public Comment

Written comments on the proposal may be submitted to Jill Seime, Senior Rate Analyst in the Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, MC-H400, Austin, Texas 78708-5200; by fax (512) 491-1983 or by e-mail at Jill.Seime@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register.*

Statutory Authority

The amendments and new rule are proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; and Human Resources Code §32.021, and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas.

The proposed rules affect the Human Resources Code, Chapter 32, and the Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

§355.8061. Payment for Hospital Services.

(a) The Health and Human Services Commission (HHSC [~~commission~~]) or its designated agent shall reimburse hospitals approved for participation in the Texas Medical Assistance Program for covered Title XIX hospital services provided to eligible Medicaid recipients. The Texas Title XIX State Plan for Medical Assistance provides for reimbursement of covered hospital services to be determined as specified in paragraphs (1) - (4) of this subsection.

(1) The amount payable for inpatient hospital services shall be determined as specified in §355.8052 of this title (relating to Inpatient Hospital Reimbursement Methodology); §355.8054 of this title (relating to Children's Hospital Reimbursement Methodology); §355.8056 of this title (relating to State-Owned Teaching Hospital Reimbursement Methodology), and §355.8063 of this title (relating to Reimbursement Methodology for Inpatient Hospital Services).

(2) The amount payable for outpatient hospital services shall be determined under similar methods and procedures used in the Social Security Act, Title XVIII, as amended, effective October 1, 1982 through July 31, 2000, by Public Law 97-248, except as may be otherwise specified by HHSC [~~the Health and Human Services Commission~~]. For the period of September 1, 1999 through and including September 30, 2001, payments to all providers were at 80.3% of allowed costs. For the period beginning October 1, 2001, Medicaid reimbursement for outpatient hospital services for high-volume providers, as defined by the commission, shall be at 84.48% of allowable cost. For the remaining providers, reimbursement for outpatient hospital services shall be at 80.3% of allowable cost. For the purpose of establishing the proposed discount factor, a high-volume provider is defined as one, which is paid at least $200,000 during calendar year 2004. Any subsequent changes to the discount will require HHSC to hold a public hearing on proposed reimbursements before [~~the~~] HHSC approves any changes. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed reimbursements. Notice of the hearing will be provided to the public. The notice of the public hearing will identify the name, address, and telephone number to contact for the materials pertinent to the proposed reimbursements. At least ten working days before the public hearing takes place, material pertinent to the proposed change will be made available to the public. This material will be furnished to anyone who requests it. After the public hearing, if negative comments are received, a summary of the comments made during the public hearing will be presented to [~~the~~] HHSC. Reimbursement for outpatient hospital surgery is limited to the lesser of the amount reimbursed to ambulatory surgical centers (ASCs) for similar services, the hospital's actual charge, the hospital's customary charge, or the allowable cost determined by the commission or its designee.

(3) Variances shall be accounted for in the Texas State Plan for Medical Assistance or as otherwise specified by the commission.

(4) Except as otherwise provided in this chapter [~~Notwithstanding other provisions of this chapter~~] and subject to the availability of funds, supplemental payments will be made each state fiscal year in accordance with this paragraph to eligible hospitals that serve high volumes of Medicaid and uninsured patients.

(A) Effective September 1, 2009, supplemental payments to certain eligible publicly-owned or -affiliated urban hospitals are determined and paid in accordance with §355.8068 of this title (relating to Supplemental Payments to Certain Urban Hospitals). [~~Supplemental payments are available under this paragraph for outpatient hospital services provided by a non-state owned or operated, publicly-owned hospital or hospital affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis counties on or after July 6, 2001. Supplemental payments will be made for outpatient services on or after June 11, 2005, for Midland, Potter, and Randall Counties.~~]

(B) Notwithstanding the provisions of subparagraph (A) of this paragraph, all hospitals that are eligible to receive funding under §355.8063(t)(2)[~~(4)~~] of this title shall also be eligible to receive funding under this paragraph. Supplemental payments will be made for outpatient services on or after June 11, 2005, for hospitals in Hidalgo, Maverick, Montgomery, Travis, Bexar, and Webb counties. Supplemental payments will be made for outpatient services on or after November 12, 2005, for eligible hospitals in all other counties in the State of Texas.

(C) Notwithstanding the provisions of subparagraphs (A) and (B) of this paragraph, all hospitals that are eligible to receive funding under §355.8069 of this title (relating to Supplemental Payments to Certain Rural Public Hospitals) shall also be eligible to receive funding under this paragraph. Supplemental payments are available under this section for outpatient hospital services provided by certain rural public hospitals on or after September 1, 2007.

(D) State funding for supplemental payments authorized under this paragraph will be limited to and obtained through intergovernmental transfers of local or hospital district funds. State funding for supplemental payments authorized under subparagraph (B) of this paragraph will be limited to and obtained through intergovernmental transfers of local governmental entity or hospital district funds or transfer of State General Revenue. The supplemental payments described in this subsection will be made in accordance with the applicable regulations regarding the Medicaid upper payment limit provisions codified at 42 CFR [~~C.F.R.~~] §447.321.

[~~(E) The non-state owned or operated, publicly-owned hospital or hospital affiliated with a hospital district in a county listed in subparagraph (A) of this paragraph that incurs the greatest amount of cost for providing services to Medicaid and uninsured patients will be eligible to receive supplemental payments. Any hospital eligible under subparagraph (B) of this paragraph will be eligible to receive supplemental payments. The supplemental payments authorized under this subsection are subject to the following limits:~~]

[~~(i)~~ ~~In each state fiscal year the amount of inpatient supplemental payments and outpatient supplement payments may not exceed the hospital's "hospital specific limit," as determined under §355.8065(f)(2)(E) of this title (relating to Reimbursement to Disproportionate Share Hospitals (DSH)) for DSH hospitals; and~~]

[~~(ii)~~ ~~The amount of outpatient supplemental payments and fee-for-service Medicaid outpatient payments the hospital receives in a state fiscal year may not exceed Medicaid billed charges for outpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 C.F.R. §447.325.~~]

(E) [~~(F)~~] An eligible hospital will receive quarterly supplemental payments. The quarterly payments will be limited to one-fourth of the difference between the hospital's Medicaid fee-for-service outpatient Medicaid payments received and 100% of Medicaid allowable outpatient hospital cost. Medicaid payments and cost will be based on a twelve consecutive-month period of fee-for-service claims data selected by HHSC.

(F) [~~(G)~~] For purposes of calculating the "hospital specific limit" under this paragraph, the "cost of services to uninsured patients" and "Medicaid shortfall," as defined by §355.8065(b)(5) and (16) of this title, will be adjusted as follows:

(i) The [~~the~~] amount of Medicaid payments (including inpatient and outpatient supplemental payments) that exceed Medicaid cost will be subtracted from the "Medicaid Shortfall."

(ii) The amount of the "Medicaid shortfall," as adjusted in accordance with clause (i) of this subparagraph, will be subtracted from the "cost of services to uninsured patients" to ensure that, during any state fiscal year, a hospital does not receive more in total Medicaid payments (inpatient and outpatient payments, graduate medical education payments, supplemental payments and disproportionate share hospital payments) than its cost of serving Medicaid patients and patients without health insurance.

(5) Notwithstanding other provisions of this section [~~attachment~~], supplemental payments will be made each state fiscal year in accordance with this subsection to state government-owned or operated hospitals for outpatient services provided to Medicaid patients.

(A) Supplemental payments are available under this subsection for outpatient hospital services provided by state government-owned or operated hospitals on or after December 13, 2003. To qualify for a supplemental payment, the hospital must be owned or operated by the state of Texas.

(B) The aggregate supplemental payment amount will be the annual difference between the aggregate upper payment limit and the outpatient fee-for-service Medicaid payments made to the state government-owned or operated hospitals under this section [~~attachment~~]. The aggregate upper payment limit will be calculated, based on Medicare payment principles and in accordance with the federal upper limit regulations at 42 CFR §447.321, using the most recent cost report data available.

(C) The amount of the supplemental payment made to each state government-owned or operated hospital will be determined by:

(i) dividing each hospital's fee-for-service Medicaid payments by the sum of the Medicaid fee-for-service payments of all state government-owned of operated hospitals; and

(ii) multiplying the percentage calculated in clause (i) of this subparagraph by the aggregate supplemental payment calculated in subparagraph (B) of this paragraph.

(D) Supplemental payments determined under this subsection will be calculated annually and paid quarterly.

(E) Supplemental payments made under this subsection when combined with other outpatient payments made under this section [~~attachment~~] shall not exceed the maximum amounts allowable under applicable federal regulations at 42 CFR §447.325.

(b) Title XIX providers may not carry forward those unreimbursed costs attributed to either the lower costs or charge limitations authorized by 42 CFR [~~Code of Federal Regulations~~] §405.455 et seq.,

effective for all accounting periods beginning on or after January 1, 1982.

(c) The direct and indirect costs of caring for charity patients shall have no relationship to eligible recipients of the Texas Medical Assistance program and are not allowable costs under the Texas Title XIX Medical Assistance program. Obligations by hospitals to provide free care, under the Hill-Burton Act or any other arrangement as a condition to secure federal grants or loans, are not recognized as a cost under the Texas Medical Assistance program.

(d) The contents of subsections (a) - (c) of this section do not describe the amount, duration, or scope of services provided to eligible recipients under the Texas Medical Assistance Program.

§355.8063. Reimbursement Methodology for Inpatient Hospital Services.

(a) - (s) (No change.)

(t) Non-State Owned Hospital Supplemental Inpatient Payments. Except as otherwise provided in this chapter [~~Notwithstanding other provisions of this chapter~~], supplemental payments will be made each state fiscal year in accordance with this subsection to eligible hospitals that serve high volumes of Medicaid and uninsured patients.

(1) Effective September 1, 2009, supplemental payments to certain eligible publicly-owned or -affiliated urban hospitals are determined and paid in accordance with §355.8068 of this title (relating to Supplemental Payments to Certain Urban Hospitals).

[~~(1) Supplemental payments are available under this subsection for inpatient hospital services provided by a publicly-owned hospital or hospital affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Midland, Potter, Randall, Tarrant, and Travis counties. Supplemental payments will be made for inpatient services on or after July 6, 2001, for Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis counties. Supplemental payments will be made for inpatient services on or after February 7, 2004, for Midland County. Supplemental payments will be made for inpatient services on or after May 29, 2004 for Potter and Randall counties.~~]

[~~(2) State funding for supplemental payments authorized under this paragraph will be limited to and obtained through intergovernmental transfers of local or hospital district funds. The supplemental payments described in this paragraph will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 C.F.R. §447.272.~~]

[~~(3) In each county listed in paragraph (1) of this subsection, the publicly-owned hospital or hospital affiliated with a hospital district that incurs the greatest amount of cost for providing services to Medicaid and uninsured patients, will be eligible to receive supplemental high volume payments. The supplemental payments authorized under this paragraph are subject to the following limits:~~]

[~~(A) In each state fiscal year the amount of any inpatient supplemental payments and outpatient supplemental payments may not exceed the hospital's "hospital specific limit," as determined under §355.8065(f)(2)(E) of this chapter (relating to Reimbursement to Disproportionate Share Hospitals (DSH)) for DSH hospitals; and~~]

[~~(B) The amount of inpatient supplemental payments and fee-for-service Medicaid inpatient payments the hospital receives in a state fiscal year may not exceed Medicaid inpatient billed charges for inpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 CFR §447.271.~~]

(2) [~~(4)~~] Notwithstanding the provisions of paragraph (1) [~~paragraphs (1) - (3)~~] of this subsection, a privately-operated hospital that executes an indigent care affiliation agreement (as defined in this subsection) with a hospital district or state or local governmental entity is eligible to receive supplemental payments under this paragraph. The purpose of the affiliation is to pay for unreimbursed care to the Medicaid population to ensure the continued viability of the communities' Medicaid providers.

(A) Supplemental payments will be made for inpatient services on or after June 11, 2005, for eligible hospitals in Hidalgo, Maverick, Montgomery, Travis, Bexar, and Webb counties. Supplemental payments will be made for inpatient services on or after November 12, 2005, for eligible hospitals in all other counties in the State of Texas.

(B) A hospital that is eligible to receive supplemental payments under this paragraph must provide a copy of the fully executed indigent care affiliation agreement to HHSC prior to payment of any supplemental funds under this paragraph.

(C) An eligible hospital must certify, on a form prescribed by HHSC and prior to payment of any supplemental funds under this paragraph, the following:

(i) No part of any supplemental payment paid to the hospital under this paragraph will be returned or reimbursed to the hospital district or state or local governmental entity;

(ii) No part of any supplemental payment paid to the hospital under this paragraph will be used to pay a contingent fee, consulting fee, or legal fee associated with the hospital's receipt of the supplemental funds; and

(iii) The person signing the certification on behalf of the hospital is legally authorized to bind the hospital and to certify the matters described in the certification.

(D) A hospital district or state or local governmental entity must certify, on a form prescribed by HHSC and prior to payment of any supplemental funds under this paragraph, the following:

(i) The hospital district or state or local governmental entity has not received and has no agreement to receive, any portion of the funds paid to an eligible hospital that has executed an affiliation agreement with the hospital district or state or local governmental entity;

(ii) The hospital district or state or local governmental entity has not entered into a contingent fee arrangement related to the hospital district's or state or local governmental entity's participation in the supplemental payment program authorized under this paragraph;

(iii) The hospital district or state or local governmental entity is authorized to participate in the supplemental payment program authorized under this paragraph pursuant to a vote of the hospital district's or state or local governmental entity's governing body in a public meeting preceded by public notice published in accordance with the hospital district's or state or local governmental entity's usual and customary practices or the Texas Open Meetings Act, as applicable;

(iv) All affiliation agreements, consulting agreements, or legal services agreements executed by the hospital district or state or local governmental entity related to the hospital district's or state or local governmental entity's participation in the supplemental payment program authorized under this paragraph are available for public inspection upon request.

(E) Beginning August 31, 2008, each participating hospital and hospital district or state or local governmental entity must submit a fully executed indigent care affiliation agreement as well as

certification forms on or before August 31st of each fiscal year to be eligible to receive supplemental payments under this paragraph during the following fiscal year.

(F) If the federal Centers for Medicare and Medicaid Services (CMS), the United States Department of Health and Human Services, or other responsible legal authority recoups federal financial participation related to an eligible hospital's receipt and/or use of supplemental payments authorized under this paragraph, HHSC may recoup an amount equivalent to the amount of supplemental payments recouped by CMS. Supplemental payments under this paragraph may be subject to any adjustments for payments made in error, including, without limitation, adjustments under §371.1703 of this title (relating to recovery of overpayments), 42 CFR [~~C.F.R.~~] part 455, and chapter 403, Texas Government Code. HHSC will send a notice of recoupment to the hospital and will recoup from any current or future Medicaid payments as follows:

(i) HHSC will recoup from the hospital against which the disallowance was directed;

(ii) If, within 30 days of the hospital's receipt of HHSC's written notice of recoupment, the hospital has not paid the full amount of the recoupment or entered into an agreement, in writing, with HHSC, HHSC may withhold any or all Medicaid payments from the hospital until such time as HHSC has recovered an amount equal to the hospital's disallowance. If HHSC determines that recovery through a withhold is not feasible, HHSC may recover the amount of the CMS recoupment from the other affiliated hospitals that are a party to the same indigent care affiliation under this paragraph through a withhold of any or all Medicaid payments until such time as HHSC has recovered an amount equal to the hospital's disallowance unless the recoupment is prohibited by law.

(G) Funding of supplemental payments under this paragraph shall be disbursed as follows:

(i) Supplemental payments available under this paragraph shall be payable to a hospital affiliated with a hospital district or state or local governmental entity in proportion to the amount transferred by the hospital district or state or local governmental entity affiliated with the private hospital, subject to legislative appropriation. Such supplemental payments will be based on calculations made by HHSC and will be made quarterly, beginning April 1, 2007.

(ii) If a hospital district or state or local governmental entity does not transfer to HHSC sufficient funding for the time period specified to generate the full amount allowable under this paragraph, each hospital affiliated with that hospital district or state or local governmental entity will receive a portion of the supplemental payment under paragraph (3) [~~(5)~~] of this subsection based on that hospital's percentage of the full entitlement for all hospitals affiliated with that hospital district or state or local governmental entity.

(iii) HHSC will issue one supplemental payment for a hospital for inpatient services the hospital provided on or before August 31, 2006, if the hospital meets the criteria of subparagraphs (A) - (C) of this paragraph no later than May 31, 2007, and if a sufficient amount of funds (as determined by HHSC) are transferred to HHSC to support the one-time supplemental payment no later than December 1, 2007. A hospital district or state or local governmental entity must notify HHSC in a manner prescribed by HHSC of the date it intends to transfer funds related to the supplement payment authorized under this subparagraph. The supplemental payment will be processed for each participating hospital based on the amount of funds transferred to HHSC up to the calculated maximum payment for the applicable retroactive time period. A hospital that satisfies the criteria of subparagraphs (A) - (C) of this paragraph after May 31, 2007, will not be eligible for the supplemental payment authorized under this subparagraph but will be eligible to receive regular supplemental payments under paragraph (3) [~~(5)~~] of this subsection. If the full amount of the calculated intergovernmental transfer (IGT) transfer is not made by the transfer deadlines specified by HHSC, the supplemental payment for that time period will be calculated based on the amount of the funds transferred. Regular quarterly supplemental payments for state fiscal year 2007 for which IGT funds are received will be made, beginning in April 2007, to each participating hospital for which a copy of the fully executed indigent care affiliation agreement, as well as any required certification forms, have been timely received.

(iv) Annual retroactive supplemental payments will be processed once for each state fiscal year, beginning with state fiscal year 2007, in September of the following calendar year (September 2008 for state fiscal year 2007) provided HHSC determines there is sufficient room available for funding under the applicable aggregate upper payment limit for private hospitals. Hospital districts or state or local governmental entities must notify HHSC Rate Analysis in a manner prescribed by HHSC if they intend to transfer funds related to the annual retroactive payments. If HHSC determines that the retroactive funding claimed pursuant to this clause will exceed the applicable aggregate upper payment limit for private hospitals, HHSC will reduce the amount of the transfer for the retroactive payment under this clause proportionately for each participating private hospital in an amount sufficient to ensure compliance with the applicable aggregate upper payment limit. If the retroactive supplemental payment calculation results in the verification that a specific hospital or hospitals were overpaid for the retroactive time period, HHSC will initiate the same process as outlined in subparagraph (F)(i) - (ii) of this paragraph to recover the amount of the overpayment.

(H) State funding for supplemental payments authorized under this paragraph will be limited to and obtained through intergovernmental transfers of local governmental entity or hospital district funds or transfer of State General Revenue. The supplemental payments described in this subsection will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 CFR [~~C.F.R.~~] §447.272.

(3) [~~(5)~~] An eligible hospital under this subsection will receive quarterly supplemental payments. The quarterly payments will be limited to one-fourth of the lesser of:

(A) The difference between the hospital's Medicaid inpatient billed charges and Medicaid payments the hospital receives for services provided to fee-for-service Medicaid recipients. Medicaid billed charges and payments will be based on a twelve consecutive-month period of fee-for-service claims data selected by HHSC; or

(B) The difference between the hospital's "hospital specific limit," as determined under §355.8065(f)(2)(E) of this chapter (relating to Reimbursement to Disproportionate Share Hospitals (DSH)) for DSH hospitals and the hospital's DSH payments as determined by the most recently finalized DSH reporting period.

(4) [~~(6)~~] For purposes of calculating the "hospital specific limit" in paragraph (3) [~~(5)~~](B) of this subsection, the "cost of services to uninsured patients, " as defined by §355.8065(b)(5) of this chapter and "Medicaid shortfall," as defined by §355.8065(b)(16) of this chapter, will be adjusted as follows:

(A) The amount of Medicaid payments (including inpatient and outpatient supplemental payments) that exceed Medicaid cost will be subtracted from the "Medicaid shortfall."

(B) The amount of the "Medicaid shortfall," as adjusted in accordance with subparagraph (A) of this paragraph, will be sub-

tracted from the "cost of services to uninsured patients" to ensure that, during any state fiscal year, a hospital does not receive more in total Medicaid payments (inpatient and outpatient rate payments, graduate medical education payments, supplemental payments and disproportionate share hospital payments) than its cost of serving Medicaid patients and patients with no health insurance.

(u) - (w) (No change.)

§355.8068. Supplemental Payments to Certain Urban Hospitals.

(a) Introduction. Notwithstanding other provisions of this subchapter, supplemental payments are available under this section for inpatient and outpatient hospital services provided by eligible publicly-owned or -affiliated urban hospitals that serve high volumes of Medicaid and uninsured patients.

(b) Definitions. When used in this section, the following terms have the following meanings, unless the context clearly indicates otherwise.

(1) Disproportionate Share Hospital--Hospitals participating in the Texas Medical Assistance (Medicaid) program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for additional reimbursement from the disproportionate share hospital (DSH) fund.

(2) Disproportionate Share Hospital (DSH) Limit--DSH Limit has the meaning assigned to the term "hospital specific limit" by §355.8065 of this title (relating to Additional Reimbursement to Disproportionate Share Hospitals).

(3) DSH Room--The difference between a hospital's DSH Limit and the total Medicaid DSH payments to the hospital for the fiscal year.

(4) DSH Reporting Period--Disproportionate Share Payments associated with the most recent state fiscal period between September 1 and August 31.

(5) Medicaid Allowable Outpatient Hospital Costs--Costs remaining when total billed outpatient hospital charges are reduced by a hospital outpatient reduction factor in accordance with §355.8061(a)(2) of this title (relating to Payment for Hospital Services).

(6) Public Funds--Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of the governmental entity that owns or that is affiliated with the hospital. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds, such as the private operator of a hospital district's facility.

(7) Publicly-Owned or -Affiliated Hospital--A hospital owned by or affiliated with a city, county, hospital authority or hospital district.

(c) Eligible hospitals. Supplemental payments are available under this section for inpatient and outpatient hospital services provided by publicly-owned hospitals in Bexar, Brazoria, Dallas, Ector, El Paso, Fort Bend, Harris, Lubbock, Nueces, Midland, Tarrant, Travis, and Wichita counties; and a hospital located in Potter County that is affiliated with the Amarillo Hospital District. The publicly-owned or -affiliated hospital or hospitals in each listed county that incur the greatest cost(s) for providing services to Medicaid and uninsured patients may be eligible to receive supplemental payments. No more than two hospitals in any county may be eligible.

(d) Dates of eligibility. Supplemental payments will be made for inpatient and outpatient services on or after July 6, 2001, for hospitals in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis counties. Supplemental payments will be made for inpatient services on or after February 7, 2004, for hospitals in Midland County. Supplemental payments will be made for inpatient services on or after May 29, 2004, for a hospital in Potter County affiliated with the Amarillo Hospital District. Supplemental payments will be made for outpatient services on or after June 11, 2005, for hospitals in Midland County and a hospital in Potter County affiliated with the Amarillo Hospital District. Supplemental payments will be made for inpatient and outpatient services provided on or after September 1, 2009, for hospitals in Brazoria, Fort Bend, and Wichita counties, as well as any hospital in Dallas County or Harris County that was not eligible as of February 7, 2004, subject to the limits in subsection (c) of this section.

(e) Source of funding. State funding for supplemental payments authorized under this section will be limited to and obtained through intergovernmental transfers of public funds.

(f) Inpatient Supplemental Payments. Hospital inpatient supplemental payments are calculated as follows:

(1) Supplemental payment limits. The supplemental payments authorized under this subsection are subject to the following limits:

(A) For Disproportionate Share Hospitals, in each state fiscal year the amount of any inpatient supplemental payments and outpatient supplemental payments may not exceed the hospital's DSH Limit; and

(B) For all eligible hospitals, the amount of inpatient supplemental payments and fee-for-service Medicaid inpatient payments the hospital receives in a state fiscal year may not exceed Medicaid inpatient billed charges for services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 Code of Federal Regulations (CFR) §447.271.

(2) Payment frequency and methodology. An eligible hospital under this subsection will receive quarterly supplemental payments.

(A) For Disproportionate Share Hospitals, the quarterly payments will be limited to the lesser of:

(i) One-fourth of the difference between all payments received for a hospital's eligible paid inpatient Medicaid claims and the corresponding billed charges for those claims for services provided to fee-for-service Medicaid recipients during a twelve-month period designated by the Health and Human Services Commission (HHSC); or

(ii) One-fourth of the DSH Room as calculated for the most recently finalized DSH reporting period.

(B) For non-Disproportionate Share Hospitals, the quarterly payments will be limited to one-fourth of the difference between all payments received for a hospital's eligible paid inpatient Medicaid claims and the corresponding billed charges for those claims for services provided to fee-for-service Medicaid recipients during a twelve-month period designated by HHSC.

(3) Aggregate Medicaid upper payment limit. The supplemental payments described in this subsection will be made in accordance with the applicable regulations regarding the Medicaid upper payment limit provisions codified at 42 CFR §447.272.

(g) Outpatient Supplemental Payments. Hospital outpatient supplemental payments are calculated as follows:

(1) Supplemental payment limits. The supplemental payments authorized under this subsection are subject to the following limits:

(A) For Disproportionate Share Hospitals, in each state fiscal year the amount of any inpatient supplemental payments and outpatient supplemental payments may not exceed the hospital's DSH Limit; and

(B) For all eligible hospitals, the amount of outpatient supplemental payments and fee-for-service Medicaid outpatient payments the hospital receives in a state fiscal year may not exceed Medicaid billed charges for outpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 CFR §447.325.

(2) Payment frequency and methodology. An eligible hospital may receive quarterly supplemental payments. The quarterly payments will be limited to one-fourth of the difference between the hospital's Medicaid fee-for-service outpatient payments received and 100% of Medicaid allowable outpatient hospital costs during a twelve-month period designated by HHSC.

(3) Aggregate Medicaid Upper Payment Limit. The supplemental payments described in this subsection will be made in accordance with the applicable regulations regarding the Medicaid upper payment limit provisions codified at 42 CFR §447.321.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 8, 2009.

TRD-200902276
Steve Aragón
General Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 424-6576

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TITLE 4. AGRICULTURE

PART 2. TEXAS ANIMAL HEALTH COMMISSION

CHAPTER 45. REPORTABLE DISEASES

4 TAC §45.2

The Texas Animal Health Commission (TAHC or commission) proposes amendments to Chapter 45, concerning Reportable Diseases, §45.2, concerning Duty to Report. The Texas Agriculture Code, Chapter 161, §161.101 requirements provide for the duty of a veterinarian, veterinary diagnostic laboratory or a person having care, custody, or control of an animal to report specified animal health diseases to the TAHC. The commission has a specific list of diseases reportable in Chapter 45 of the commission rules. This proposal is for the purpose of modifying several elements of the rule. During the 81st Texas Legislative Session House Bill (HB) 4006 was passed and adopted, which modified the reportable disease requirement in §161.101.

Section 45.2 contains outdated language regarding requirements to report diseases to the agency. The current statute authorizes TAHC to adopt rules requiring the reporting of diseases to TAHC if the disease is named on "List A" of the Office International Des Epizooties (OIE). However, the OIE no longer maintains "List A." HB 4006 removes the reference to "List A" from the statute and specifies, in its place, a disease reportable to the OIE. The bill also adds three diseases to the list of diseases that must be reported to TAHC. Therefore, the commission is collaterally removing the distinction in §45.2(a) by removing the destination for a List A disease. Also, HB 4006 legislatively ratified three diseases already adopted in Chapter 45 as being reportable. They were Equine Viral Arteritis (EVA), Equine Herpes Virus-1 (EHV-1) and Bovine trichomonosis. As such the single asterisk is being removed as these diseases have now been supported by the legislative action. Lastly, the commission is proposing to remove Duck virus enteritis (Herpesvirus) as a reportable disease. It is no longer a listed Office International Des Epizooties Disease and is therefore recommended for removal.

FISCAL NOTE

Mrs. Angela Jenkins, Director of Financial Services, Texas Animal Health Commission, has determined for the first five-year period the rule is in effect, there will be no additional fiscal implications for state or local government as a result of enforcing or administering the rule. Implementation of this rule poses no significant fiscal impact on small or micro-businesses. There will be no economic costs to individuals required to comply with the rule as proposed.

PUBLIC BENEFIT NOTE

Mrs. Jenkins also has determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will allow us to be made quickly aware of specific diseases that may be diagnosed in this state.

LOCAL EMPLOYMENT IMPACT STATEMENT

In accordance with Government Code, §2001.022, this agency has determined that the proposed rule will not impact local economies and, therefore, did not file a request for a local employment impact statement with the Texas Workforce Commission.

TAKINGS ASSESSMENT

The agency has determined that the proposed governmental action will not affect private real property. This proposed rule is an activity related to the handling of animals, including requirements concerning testing, movement, inspection, identification, reporting of disease, and treatment, in accordance with 4 TAC §59.7, and are, therefore, compliant with the Private Real Property Preservation Act in Government Code, Chapter 2007.

REQUEST FOR COMMENT

Comments regarding the proposed amendments may be submitted to Delores Holubec, Texas Animal Health Commission, 2105 Kramer Lane, Austin, Texas 78758, by fax at (512) 719-0721 or by e-mail at "comments@tahc.state.tx.us."

STATUTORY AUTHORITY

The amendment is proposed under the Texas Agriculture Code, Chapter 161, §161.041(a) and (b), and §161.046 which authorizes the commission to promulgate rules in accordance with the Texas Agriculture Code. Section 161.101 provides that the commission may adopt rules that require a veterinarian, a veterinary diagnostic laboratory, or a person having care, custody, or control of an animal to report a disease not covered by subsection (a) or (b) if the commission determines that action to be necessary for the protection of animal health in this state. The commission shall immediately deliver a copy of a rule adopted under this subsection to the appropriate legislative oversight committees.

A rule adopted by the commission under this subsection expires on the first day after the last day of the first regular legislative session that begins after adoption of the rule unless the rule is continued in effect by act of the legislature. HB 4006 relating to veterinarian reports of diseased animals was passed during the 81st Legislative Session and amended the requirements found in §161.101.

No other statutes, articles, or codes are affected by the amendments.

§45.2. Duty To Report.

(a) A veterinarian, a veterinary diagnostic laboratory or a person having care, custody, or control of an animal, shall report the existence of the following diseases among livestock, exotic livestock, domestic fowl, or exotic fowl to the commission within 24 hours after diagnosis. The following listing includes diseases and conditions that are Office International Des Epizooties [~~List A~~] Diseases, Foreign Animal Diseases, National Program Diseases or Texas Animal Health Commission Designated Diseases.
Figure: 4 TAC §45.2(a)

(b) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 8, 2009.

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Gene Snelson
General Counsel
Texas Animal Health Commission
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For further information, please call: (512) 719-0700

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CHAPTER 51. ENTRY REQUIREMENTS

4 TAC §51.8

The Texas Animal Health Commission (commission) proposes amendments to Chapter 51, concerning Entry Requirements, §51.8, concerning Cattle. The purpose of these amendments to Chapter 51 is to provide entry requirements and entry permits for agriculture animals. This proposal is regarding entry requirements for a trichomoniasis test for breeding bulls from Mexico, Canada and other foreign countries entering the state, as well as potential testing of exhibition bulls capable of breeding and staying within the state for more than sixty (60) days. Also, a permit requirement is being added for all "M" brand steers, which are recognized as potential rodeo and/or roping stock.

The commission is adding to §51.8(b)(4) the requirement that all "M" brand steers, which are recognized as potential rodeo and/or roping stock, imported into Texas from another state shall obtain an entry permit. The reason for this proposal is to ensure that all of these exhibition animals obtain a permit so that we can adequately account for those animals entering the state and meeting the existing test requirement. Without having them obtain permits we are able to assure compliance with our entry requirements only after entry and possible commingling with Texas cattle at an event. Because this group of animals constitutes a higher risk and concern for tuberculosis, the commission wants to ensure that we are able to identify those high risk animals and ensure they meet the test requirements.

Under our trichomoniasis entry requirements for cattle the commission is proposing to add additional requirements to ensure any potential breeding animals entering the state are trichomoniasis free or to determine if the animals are entering for a purpose other than breeding. This requirement is for all bulls entering Texas for the purpose of participating at fairs, shows, exhibition and/or rodeo, which are twelve (12) months of age or older and capable of breeding, to obtain a permit, in accordance with §51.2(a) of this chapter, prior to entry into the state. Bulls permitted for entry into the State of Texas under the provisions of this subsection shall not be commingled with female cattle or used for breeding. Bulls that stay in the state more than sixty (60) days must be tested negative for trichomoniasis with an official culture test or official Polymerase Chain Reaction (PCR) test. This proposed rule is intended to close a potential loophole through which animals that come to this state for the purpose of exhibition are diverted to use for breeding purposes, thus avoiding the entry testing requirements.

To ensure breeding bulls originating from Mexico are not infected with trichomoniasis, the commission is proposing to require that all breeding bulls, which are twelve (12) months of age or older, entering from Mexico, must enter on a permit to a premises of destination in Texas and remain under Hold Order until tested negative for Trichomoniasis.

The commission is also proposing the same test requirement on breeding bulls from Canada to make sure they meet the same standard.

FISCAL NOTE

Mrs. Angela Jenkins, Director for Finance, Texas Animal Health Commission, has determined for the first five-year period the rule is in effect, there will be no significant additional fiscal implications for state or local government as a result of enforcing or administering the rule. An Economic Impact Statement (EIS) is required if the proposed rule has an adverse economic effect on small businesses. The agency has evaluated the requirements and determined that there is not an adverse economic impact because these entry requirement are serving to protect all breeding animals in the state from being infected with Trichomoniasis and/or Tuberculosis from sources outside the state. Therefore, the commission has determined that there is not an adverse impact on the animals entering the state because the requirement is intended to protect the animals within the state and therefore there is no need to do an EIS. There will be no effect on small or micro businesses. There will be no economic costs to individuals required to comply with the rule as proposed.

PUBLIC BENEFIT NOTE

Mrs. Jenkins also has determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be to protect our livestock industry from exposure to Trichomoniasis from out of state breeding bulls as well as ensuring that rodeo animals must get a permit in order to ensure they are properly tested.

LOCAL EMPLOYMENT IMPACT STATEMENT

In accordance with Government Code, §2001.022, this agency has determined that the proposed rule will not impact local economies and, therefore, did not file a request for a local employment impact statement with the Texas Workforce Commission.

TAKINGS ASSESSMENT

The agency has determined that the proposed governmental action will not affect private real property. This proposed rule is an activity related to the handling of animals, including requirements concerning testing, movement, inspection, identification, reporting of disease, and treatment, in accordance with 4 TAC, §59.7, and are, therefore, compliant with the Private Real Property Preservation Act in Government Code, Chapter 2007.

REQUEST FOR COMMENT

Comments regarding the proposed amendment may be submitted to Delores Holubec, Texas Animal Health Commission, 2105 Kramer Lane, Austin, Texas 78758, by fax at (512) 719-0721 or by e-mail at "comments@tahc.state.tx.us."

STATUTORY AUTHORITY

The amendment is proposed under the following statutory authority as found in Chapter 161 of the Texas Agriculture Code. The commission is vested by statute, §161.041(a), with the requirement to protect all livestock, domestic animals, and domestic fowl from disease. The commission is authorized, by §161.041(b), to act to eradicate or control any disease or agent of transmission for any disease that affects livestock. If the commission determines that a disease listed in §161.041 of this code or an agent of transmission of one of those diseases exists in a place in this state among livestock, or that livestock are exposed to one of those diseases or an agent of transmission of one of those diseases, the commission shall establish a quarantine on the affected animals or on the affected place. That authority is found in §161.061.

As a control measure, the commission, by rule may regulate the movement of animals. The commission may restrict the intrastate movement of animals even though the movement of the animals is unrestricted in interstate or international commerce. The commission may require testing, vaccination, or another epidemiologically sound procedure before or after animals are moved. That authority is found in §161.054. An agent of the commission is entitled to stop and inspect a shipment of animals or animal products being transported in this state in order to determine if the shipment originated from a quarantined area or herd; or determine if the shipment presents a danger to the public health or livestock industry through insect infestation or through a communicable or noncommunicable disease. That authority is found in §161.048.

Section 161.005 provides that the commission may authorize the executive director or another employee to sign written instruments on behalf of the commission. A written instrument, including a quarantine or written notice signed under that authority, has the same force and effect as if signed by the entire commission.

No other statutes, articles, or codes are affected by the amendments.

§51.8. Cattle.

(a) (No change.)

(b) Tuberculosis requirements.

(1) - (2) (No change.)

(3) All dairy breed animals, including steers and spayed heifers, shall be officially identified prior to entry into the state. All sexually intact dairy cattle, that are two (2) months of age or older may enter provided that they are officially identified, and are accompanied by a certificate stating that they were negative to an official tuberculosis test conducted within 60 days prior to the date of entry. All sexually intact dairy cattle that are less than two (2) months of age must obtain a entry permit from the Commission, as provided in §51.2(a) of this chapter [~~title~~] (relating to General Requirements), to a designated facility where the animals will be held until they are tested negative at the age of two (2) months. Animals which originate from a tuberculosis accredited herd, and/or animals moving directly to an approved slaughtering establishment are exempt from the test requirement. Dairy cattle delivered to an approved feedlot for feeding for slaughter by the owner or consigned there and accompanied by certificate of veterinary inspection with a entry permit issued by the commission are exempt from testing unless from a restricted herd. In addition all sexually intact dairy cattle originating from a state or area with anything less than a tuberculosis free state status shall be tested negative for tuberculosis in accordance with the appropriate requirements for states or zones with a status as provided by Title 9 of the Code of Federal Regulations, Part 77, Sections 77.10 through 77.19, for that status, prior to entry with results of the test recorded on the certificate of veterinary inspection.

(4) All "M" brand steers, which are recognized as potential rodeo and/or roping stock, being imported into Texas from another state shall obtain a permit, prior to entry into the state, in accordance with §51.2(a) of this chapter and be accompanied by a certificate of veterinary inspection which indicates that the animal(s) were tested negative for tuberculosis within twelve months prior to entry into the state.

(5) - (7) (No change.)

(c) Trichomoniasis Requirements:

(1) All breeding bulls entering the state shall be virgin bulls not more than 24 months of age as determined by the presence of both permanent central incisor teeth in wear, or by breed registry papers; or be tested negative for Trichomoniasis with an official culture test or official Polymerase Chain Reaction (PCR) test within 30 days prior to entry into the state. Bulls that have had contact with female cattle subsequent to testing must be retested prior to entry. If the breeding bulls are virgin bulls they shall be individually identified by an official identification device and be accompanied with a breeders certification of virgin status signed by the breeder or his representative attesting that they are virgin bulls. The official identification number shall be written on the breeders certificate. All bulls tested for Trichomoniasis shall be identified by an official identification device or method at the time the initial test sample is collected. Official identification includes: Official Alpha-numeric USDA metal eartags (bangs tags), Official 840 RFID tags, Official 840 flap or bangle tags, and Official individual animal breed registry tattoo or breed registry individual animal brands, or official state of origin Trichomoniasis tags. The identification shall be recorded on the test documents or the breeders certificate and the certificate of veterinary inspection prior to entry. Non-virgin bulls shall be tested three times not less than one week apart, for each test, by official culture test or one time by official PCR test prior to entry into Texas.

(2) All bulls entering Texas for the purpose of participating at fairs, shows, exhibition and/or rodeo, which are twelve (12) months of age or older and capable of breeding may enter the state without testing or certification for trichomoniasis, but shall obtain a permit, in accordance with §51.2(a) of this chapter, prior to entry into the state. Bulls permitted for entry into the State of Texas under the provisions of this subsection shall not be commingled with female cattle or used for breeding. Bulls that stay in the state more than sixty (60) days must be tested negative for Trichomoniasis with an official culture test or official Polymerase Chain Reaction (PCR) test.

(3) All breeding bulls entering from Mexico or from any country that does not have an established trichomoniasis testing program, shall enter on and be moved by a permit, issued prior to entry, from the commission, in accordance with §51.2(a) of this chapter, to a premises of destination in Texas and remain under Hold Order un-

til tested negative for Trichomoniasis with not less than three official culture tests conducted not less than seven (7) days apart, or an official Polymerase Chain Reaction (PCR) test, within thirty (30) days after entry into the state. All bulls shall be maintained separate from female cattle until tested negative for Trichomoniasis. The Hold Order shall not be released until all other post entry disease testing requirements have been completed. All bulls tested for Trichomoniasis shall be identified by an official identification device or method at the time the initial test sample is collected. The identification shall be recorded on the test documents.

(4) All breeding bulls entering from Canada or from any country that has an established trichomoniasis testing program but for which the animals are not tested to meet the certification and testing requirements of paragraph (1) of this subsection, shall enter on and be moved by a permit, issued prior to entry, from the commission, in accordance with §51.2(a) of this chapter, to a premises of destination in Texas and remain under Hold Order until tested negative for Trichomoniasis with not less than three official culture tests conducted not less than seven (7) days apart, or an official Polymerase Chain Reaction (PCR) test within thirty (30) days of entry into the state. All bulls shall be maintained separate from female cattle until tested negative for Trichomoniasis. All bulls tested for Trichomoniasis shall be identified by an official identification device or method at the time the initial test sample is collected. The identification shall be recorded on the test documents.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Gene Snelson
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Texas Animal Health Commission
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TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 97. PLANNING AND ACCOUNTABILITY

SUBCHAPTER AA. ACCOUNTABILITY AND PERFORMANCE MONITORING

19 TAC §97.1005

(Editor's note: In accordance with Texas Government Code, §2002.014, which permits the omission of material which is "cumbersome, expensive, or otherwise inexpedient," the figure in 19 TAC §97.1005 is not included in the print version of the Texas Register. The figure is available in the on-line version of the June 19, 2009, issue of the Texas Register.)

The Texas Education Agency (TEA) proposes an amendment to §97.1005, concerning accountability and performance monitoring. The section describes the purpose of the Performance-Based Monitoring Analysis System (PBMAS) and manner in which school districts and charter school performance is reported. The section also adopts the most recently published PBMAS Manual. The proposed amendment would adopt applicable excerpts of the Performance-Based Monitoring Analysis System 2009 Manual. Earlier versions of the manual will remain in effect with respect to the school years for which they were developed.

House Bill 3459, 78th Texas Legislature, 2003, added the Texas Education Code (TEC), §7.027, limiting and redirecting monitoring done by the TEA to that required to ensure school district and charter school compliance with federal law and regulations; financial accountability, including compliance with grant requirements; and data integrity for purposes of the Public Education Information Management System (PEIMS) and accountability under TEC, Chapter 39. Legislation passed in 2005 renumbered TEC, §7.027, to TEC, §7.028. To meet this monitoring requirement, the agency developed the Performance-Based Monitoring Analysis System (PBMAS), which is used in conjunction with other evaluation systems, to monitor performance and program effectiveness of special programs in school districts and charter schools.

Agency legal counsel has determined that the commissioner of education should take formal rulemaking action to place into the *Texas Administrative Code* procedures related to the PBMAS. Given the statewide application of the PBMAS and the existence of sufficient statutory authority for the commissioner of education to formally adopt rules in this area, portions of each annual PBMAS Manual have been adopted since the first PBMAS Manual was developed in 2004-2005. The PBMAS evolves from year to year, and the intent is to annually update 19 TAC §97.1005 to refer to the most recently published PBMAS Manual.

The proposed amendment to 19 TAC §97.1005 would update the current rule by adopting excerpted sections of the PBMAS 2009 Manual. These excerpted sections describe the specific criteria and calculations that will be used to assign 2009 PBMAS performance levels.

The 2009 PBMAS includes several key changes from the 2008 system. New standards and cut points are being proposed for several PBMAS indicators, including the Limited English Proficient (LEP) Participation Rate, Career and Technical Education (CTE) Nontraditional Course Completion Rate, the Texas Assessment of Knowledge and Skills (TAKS)/TAKS (Accommodated) Participation Rate, the 3-5 Year Olds Less Restrictive Environment (LRE) Placement Rate, the 6-11 Year Olds LRE Placement Rate, the 12-21 Year Olds LRE Placement Rate, and the Special Education Discretionary Placements to In-School Suspension. The Texas English Language Proficiency Assessment System (TELPAS) Reading Multi-Year Beginning Proficiency Level Rate indicator, which was suspended for the 2008 PBMAS, has been reinstated.

A new indicator to measure the performance of LEP students not served in a Bilingual Education (BE) or English as a Second Language (ESL) program has been added to the BE/ESL program area along with a Grades 9-12 LEP Annual Dropout Rate indicator and an indicator entitled TELPAS Composite Rating Levels for Students in U.S. Schools Multiple Years. The hold harmless provision which was added to the 2008 PBMAS to address the impact of the phase-in of TAKS (Accommodated) and Grade 8 Science results has been removed. Changes to the PBMAS indicators for 2009 are marked in the manual as *"New!"* for easy reference.

The proposed amendment would also modify subsection (d) to specify that the PBMAS Manual adopted for the school years

prior to 2009-2010 will remain in effect with respect to those school years.

The proposal would establish in rule the PBMAS procedures for assigning the 2009 PBMAS performance levels. Applicable procedures will be adopted each year as annual versions of the PBMAS Manual are published. The proposed amendment would have no locally maintained paperwork requirements.

Criss Cloudt, associate commissioner for assessment, accountability, and data quality, has determined that for the first five-year period the amendment is in effect there will be no additional costs for state and local government as a result of enforcing or administering the amendment.

Dr. Cloudt has determined that for each year of the first five years the amendment is in effect the public benefit anticipated as a result of enforcing the amendment will be to continue to inform the public of the existence of annual manuals specifying PBMAS procedures by including this rule in the *Texas Administrative Code.* There is no anticipated economic cost to persons who are required to comply with the proposed amendment.

There is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

The public comment period on the proposal begins June 19, 2009, and ends July 20, 2009. Comments on the proposal may be submitted to Cristina De La Fuente-Valadez, Policy Coordination Division, Texas Education Agency, 1701 North Congress Avenue, Austin, Texas 78701, (512) 475-1497. Comments may also be submitted electronically to *rules@tea.state.tx.us* or faxed to (512) 463-0028. A request for a public hearing on the proposal submitted under the Administrative Procedure Act must be received by the commissioner of education not more than 15 calendar days after notice of the proposal has been published in the *Texas Register* on June 19, 2009.

The amendment is proposed under the Texas Education Code, §7.028, which authorizes the agency to monitor as necessary to ensure school district and charter school compliance with state and federal law and regulations.

The amendment implements the Texas Education Code, §7.028.

§97.1005. Performance-Based Monitoring Analysis System.

(a) In accordance with Texas Education Code, §7.028(a), the purpose of the Performance-Based Monitoring Analysis System (PBMAS) is to report annually on the performance of school districts and charter schools in selected program areas: bilingual education/English as a Second Language, career and technical education, special education, and certain Title programs under the federal No Child Left Behind Act. The performance of a school district or charter school is reported through indicators of student performance and program effectiveness and corresponding performance levels established by the commissioner of education.

(b) The assignment of performance levels for school districts and charter schools in the 2009 [~~2008~~] PBMAS is based on specific criteria and calculations, which are described in excerpted sections of the PBMAS 2009 [~~2008~~] Manual provided in this subsection.
Figure: 19 TAC §97.1005(b)
[~~Figure: 19 TAC §97.1005(b)~~]

(c) The specific criteria and calculations used in the PBMAS are established annually by the commissioner of education and communicated to all school districts and charter schools.

(d) The specific criteria and calculations used in the annual PBMAS manual adopted for the school years prior to 2009-2010 [~~2008-2009~~] remain in effect for all purposes, including accountability and performance monitoring, data standards, and audits, with respect to those school years.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 8, 2009.

TRD-200902274
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 475-1497

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TITLE 22. EXAMINING BOARDS

PART 16. TEXAS BOARD OF PHYSICAL THERAPY EXAMINERS

CHAPTER 329. LICENSING PROCEDURE

22 TAC §329.2

The Texas Board of Physical Therapy Examiners proposes an amendment to §329.2, License by Examination. The amendment would exempt those already licensed in another state from the additional education requirement if they have to take the national examination again.

John P. Maline, Executive Director, has determined that for the first five-year period this amendment is in effect there will be no additional costs to state or local governments as a result of enforcing or administering this amendment.

Mr. Maline has also determined that for each year of the first five-year period this amendment is in effect the public benefit will be efficient licensure of applicants who are already licensed in other states. Mr. Maline has determined that there will be no costs or adverse economic effects to small or micro businesses, therefore an economic impact statement or regulatory flexibility analysis is not required for the amendment. There are no anticipated costs to individuals who are required to comply with the rule as proposed.

Comments on the proposed amendment may be submitted to Nina Hurter, PT Coordinator, Texas Board of Physical Therapy Examiners, 333 Guadalupe, Suite 2-510, Austin, Texas 78701; email: nhurter@mail.capnet.state.tx.us. Comments must be received no later than 30 days from the date this proposed amendment is published in the *Texas Register.*

The amendment is proposed under the Physical Therapy Practice Act, Title 3, Subtitle H, Chapter 453, Texas Occupations Code, which provides the Texas Board of Physical Therapy Examiners with the authority to adopt rules consistent with this Act to carry out its duties in administering this Act.

Title 3, Subtitle H, Chapter 453, Texas Occupations Code is affected by this amendment.

§329.2. License by Examination.

(a) - (e) (No change.)

(f) Re-examination.

(1) - (2) (No change.)

(3) A person who is currently licensed in good standing in another state and who must retake the national exam to meet Texas score requirements is not required to complete additional education.

(g) - (h) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 8, 2009.

TRD-200902277
John P. Maline
Executive Director
Texas Board of Physical Therapy Examiners
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 305-6900

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22 TAC §329.3

The Texas Board of Physical Therapy Examiners proposes an amendment to §329.3, Temporary Licensure for Examination Candidates. The amendment would clarify that a temporary license will not be issued until the applicant has registered for the national examination and completed all requirements as stated in §329.1, General Licensing Requirements and Procedures.

John P. Maline, Executive Director, has determined that for the first five-year period this amendment is in effect there will be no additional costs to state or local governments as a result of enforcing or administering this amendment.

Mr. Maline has also determined that for each year of the first five-year period this amendment is in effect the public benefit will be less ambiguity regarding when the temporary licensed may be issued. Mr. Maline has determined that there will be no costs or adverse economic effects to small or micro businesses, therefore an economic impact statement or regulatory flexibility analysis is not required for the amendment. There are no anticipated costs to individuals who are required to comply with the rule as proposed.

Comments on the proposed amendment may be submitted to Nina Hurter, PT Coordinator, Texas Board of Physical Therapy Examiners, 333 Guadalupe, Suite 2-510, Austin, Texas 78701; email: nhurter@mail.capnet.state.tx.us. Comments must be received no later than 30 days from the date this proposed amendment is published in the *Texas Register.*

The amendment is proposed under the Physical Therapy Practice Act, Title 3, Subtitle H, Chapter 453, Texas Occupations Code, which provides the Texas Board of Physical Therapy Examiners with the authority to adopt rules consistent with this Act to carry out its duties in administering this Act.

Title 3, Subtitle H, Chapter 453, Texas Occupations Code is affected by this amendment.

§329.3. Temporary Licensure for Examination Candidates.

(a) Requirements. To be eligible for a temporary license, the applicant must:

(1) (No change.)

(2) register for the national physical therapy examination [~~meet all requirements as stated in §329.2 of this title (relating to Licensure by examination)~~];

(3) - (4) (No change.)

(b) - (e) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 8, 2009.

TRD-200902278
John P. Maline
Executive Director
Texas Board of Physical Therapy Examiners
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 305-6900

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 65. WILDLIFE

SUBCHAPTER A. STATEWIDE HUNTING AND FISHING PROCLAMATION

DIVISION 1. GENERAL PROVISIONS

31 TAC §65.11

The Texas Parks and Wildlife Department (the department) proposes an amendment to §65.11, concerning Lawful Means. The proposed amendment would allow the use of crossbows by all persons during the archery-only season, with an exception related to one county, and allow the use of laser sighting devices by any person with a physical disability that renders the person incapable of using a traditional firearm sighting device, provided the person possesses a physician's or optometrist's statement certifying the extent of the disability.

Under Government Code, §2001.006(b), an agency may adopt a rule in preparation for the implementation of legislation that has become law but has not taken effect. With the passage of House Bill 968 and House Bill 1805 by the 81st Texas Legislature, Regular Session, it is necessary for the department to promulgate rules to implement the provisions of the bills.

Under Parks and Wildlife Code, §43.201(a), no person may hunt deer, turkey, or javelina during an open archery season restricted to longbows, recurved bows, compound bows, or crossbows used by hunters with upper limb disabilities unless the person has acquired an archery hunting stamp. House Bill 968 removes the reference to upper-limb disabilities in connection with the use of crossbows, and makes this applicable in all counties except those in which firearms are not lawful means. The amendment allows any person, regardless of physical ability, to use a crossbow during the archery-only season, provided the person has acquired an archery stamp, except in counties where the lawful means do not allow the use of firearms (current rules prohibit the use of firearms to take deer in Grayson County) Because all

deer-hunting opportunity in Grayson County is limited to archery equipment and crossbows only, the archery stamp requirement applies to the harvest of deer at all times.

Under current §65.11, a person may hunt during an archery-open season only by means of "lawful archery equipment," which is defined by §65.3, concerning Definitions, as "longbow, compound bow or recurved bow." However, there is an exception for crossbow use by persons with an upper-limb disability. The proposed amendment would alter the definition of "lawful archery equipment" to include crossbows and eliminate the upper-limb disability requirement. This change, in concert with the provisions of House Bill 968, would provide for the use of crossbows by any person during the archery season in all counties except Grayson County, where use of crossbows at any time to take deer would be restricted to persons with an upper-limb disability.

Current §65.11 also allows a person who is legally blind to use a laser sighting device to hunt game animals and game birds during lawful hunting hours in open seasons, provided the person is assisted by a person who is not legally blind, has a hunting license; and is at least 13 years of age. House Bill 1805 provides for the use of laser sighting devices by persons with a physical disability (defined as "a documented permanent physical disability that renders the person incapable of using a traditional firearm sighting device") to hunt game animals and game birds during lawful hunting hours in open seasons, provided the person possesses a physician's or optometrist's statement certifying the extent of the disability, and is assisted by a person who does not have a physical disability, has a hunting license, and is at least 13 years of age.

The proposed amendment would alter the current rule to incorporate the provisions of House Bill 1805.

Robert Macdonald, Regulations Coordinator, has determined that for each of the first five years the rule as proposed is in effect, there will be fiscal implications to state or local government as a result of enforcing or administering the rule.

The department estimates that the maximum fiscal implications of the portion of the amendment that would allow crossbows to be used by any person during the archery-only season will be additional revenues of $172,554 per fiscal year. This figure was derived as follows. The department sold approximately 1,040,832 hunting licenses in fiscal year (FY) 2008. Of those persons, approximately 527,279 purchased the archery stamp required for participation in the archery-only season, leaving 513,533 hunting license holders who did not. Of the 512,533 persons who did not purchase an archery stamp, the department estimates that approximately 50 percent are exclusively migratory game bird hunters. The other 50 percent (256,777) hunt deer, turkey and other game that could potentially be hunted with a crossbow. From this population of 256,777 the department estimates that as many as 10 percent would actually hunt with a crossbow (25,677). At $7 per stamp, this represents a maximum net revenue gain to the department $172,554 per fiscal year, less the 4 percent agent fee charged by retailers who sell the stamp and the $0.76 electronic transaction fee charged to the department by the operator of the department's electronic licensing system (approximately $19,515 per FY). There will be no fiscal implications to units of local government as a result of administering or enforcing the amendment as proposed.

The department estimates that there will be no fiscal implications for state or local government as a result of the enforcement or administration of the portion of the amendment allows the use of laser sighting devices by persons with a physical disability.

Mr. Macdonald also has determined that for each of the first five years the rule as proposed is in effect, the public benefit anticipated as a result of enforcing or administering the rule as proposed will be the provision of additional hunting opportunity.

Under the provisions of Government Code, Chapter 2006, a state agency must prepare an economic impact statement and a regulatory flexibility analysis for a rule that may have an adverse economic effect on small businesses and micro-businesses. The department has determined that there will be no direct economic effect on small or micro-businesses or persons required to comply as a result of the proposed rule. The rule would not compel or mandate any action on the part of any entity, including small businesses or microbusinesses. In particular, the proposed rule would not add new reporting or recordkeeping requirements; require any new professional expertise, capital costs, or costs for modification of existing processes or procedures; lead to loss of sales or profits; change market competition; or increase taxes or fees. Accordingly, the department has not prepared a regulatory flexibility analysis under Government Code, Chapter 2006.

The department has not drafted a local employment impact statement under the Administrative Procedures Act, §2001.022, as the agency has determined that the rule as proposed will not impact local economies.

The department has determined that Government Code, §2001.0225 (Regulatory Analysis of Major Environmental Rules), does not apply to the proposed rule.

The department has determined that there will not be a taking of private real property, as defined by Government Code, Chapter 2007, as a result of the proposed rule.

Comments on the proposed rule may be submitted to Robert Macdonald, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, Texas 78744; (512) 389-4775, e-mail: robert.macdonald@tpwd.state.tx.us.

The amendment is proposed under Parks and Wildlife Code, §61.054, which requires the commission to specify the means or method that may be used to hunt, take, or possess game animals, game birds, or aquatic animal life.

The proposed amendment affects Parks and Wildlife Code, Chapter 61.

§65.11. Lawful Means.

It is unlawful to hunt any of the wildlife resources of this state except by the means authorized by this section and as provided in §65.19 of this title (relating to Hunting Deer with Dogs).

(1) (No change.)

(2) Archery.

(A) - (D) (No change.)

(E) Lawful archery equipment and crossbows are the only lawful means that may be used during [~~Special~~] archery-only seasons [~~are restricted to lawful archery equipment only~~], except as provided in paragraph (3) of this section.

(3) Crossbow. Except for Grayson County, crossbows [~~Crossbows~~] are lawful during archery-only seasons and any general open season. In Grayson County, no person may use a crossbow to hunt deer during any season unless the person has [~~A person having~~]

an upper-limb disability and has in immediate possession [~~may use a crossbow to hunt deer and turkey during an archery-only season, provided the person has in their immediate possession~~] a physician's statement that certifies [~~certifying~~] the extent of the disability. When hunting turkey and all game animals other than squirrels by means of crossbow:

(A) - (D) (No change.)

(4) - (5) (No change.)

(6) Use of laser sighting devices. All provisions concerning hunter education requirements apply to persons hunting with laser sighting devices under this paragraph.

(A) Use of laser sighting devices by persons who are legally blind.

(i) [~~(A)~~] A person who is legally blind may use a laser sighting device to hunt game animals and game birds during lawful hunting hours in open seasons, provided the person is assisted by a person who:

(I) [~~(i)~~] is not legally blind;

(II) [~~(ii)~~] has a hunting license; and

(III) [~~(iii)~~] is at least 13 years of age.

(ii) [~~(B)~~] A person who uses a laser sighting device under the provisions of this subparagraph must have in possession a signed statement from a physician or optometrist to the effect that the person is legally blind by the standard of Government Code, §62.104, and must present the statement to any peace officer or department employee acting within the scope of official duties.

(B) Use of laser sighting devices by persons who are physically disabled.

(i) A person with a physical disability may use a laser sighting device during lawful hunting hours in open seasons when assisted by a person who:

(I) is not a person with a physical disability or legally blind;

(II) has a hunting license; and

(III) is at least 13 years of age.

(ii) A person who uses a laser sighting device under the provisions of this subparagraph must have in possession a signed statement from a physician or optometrist certifying that the person is incapable of using a traditional firearm sighting device.

[~~(C) All provisions concerning hunter education requirements apply.~~]

(7) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 4, 2009.

TRD-200902230
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 389-4775

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 11. TEXAS JUVENILE PROBATION COMMISSION

CHAPTER 341. TEXAS JUVENILE PROBATION COMMISSION STANDARDS

SUBCHAPTER D. TREATMENT AND SAFETY

37 TAC §341.15

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The Texas Juvenile Probation Commission (TJPC) proposes the repeal of §341.15 relating to treatment and safety. The repeal is in an effort not to overlap with newly adopted standards in Chapters 350 and 358 related to abuse, neglect and exploitation investigations.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the repeal is in effect, there will be no fiscal implications for state government or small businesses as a result of enforcement or implementation.

Ms. Capers has also determined that for each year of the first five years the repeal is in effect, the public benefit expected as a result of the repeal will provide TJPC with a more accurate account in evaluating the effectiveness and services provided within the juvenile probation system. There will be no impact on small business or individuals as a result of the repeal.

Public comments on the proposed repeal may be submitted in writing to Diane Laffoon at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547. Comments may also be submitted electronically to *Diane.Laffoon@tjpc.state.tx.us* or faxed to (512) 424-6718.

This repeal is proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§341.15. Treatment and Safety.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902256
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 424-6710

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CHAPTER 343. STANDARDS FOR SECURE JUVENILE PRE-ADJUDICATION DETENTION

AND POST-ADJUDICATION CORRECTIONAL FACILITIES

The Texas Juvenile Probation Commission (TJPC) proposes the repeal of Chapter 343, §§343.1 - 343.17, 343.30 - 343.37, 343.45 - 343.52, and 343.60 - 343.68, relating to standards for secure juvenile pre-adjudication detention facilities and post-adjudication correctional facilities. The repeal is in an effort to provide structural and substantive changes from the current standards.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the repeal is in effect, there will be no fiscal implications for state or local government. There will be no fiscal implications for small businesses or individuals as a result of enforcement or implementation.

Ms. Capers has also determined that for each year of the first five years the repeal is in effect, the public benefit expected as a result of the repeal will provide TJPC with a more accurate account in evaluating the effectiveness and services provided within the juvenile probation system. There will be no impact on small business or individuals as a result of the repeal.

Public comments on the proposed repeal may be submitted in writing to Diane Laffoon at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547. Comments may also be submitted electronically to *Diane.Laffoon@tjpc.state.tx.us* or faxed to (512) 424-6718.

SUBCHAPTER A. DEFINITIONS

37 TAC §343.1

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

This repeal is proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§343.1. Definitions.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902266
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER B. PRE-ADJUDICATION AND POST-ADJUDICATION SECURE FACILITY STANDARDS

37 TAC §§343.2 - 343.17

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

This repeal is proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§343.2. Administration and Management.

§343.3. Treatment and Safety.

§343.4. Data Collection.

§343.5. Physical Plant.

§343.6. Security and Control.

§343.7. Rules and Discipline.

§343.8. Food.

§343.9. Hygiene.

§343.10. Health Care Services.

§343.11. Communications.

§343.12. Residents' Rights.

§343.13. Volunteers and Interns.

§343.14. Waivers and Variances.

§343.15. Employment of Certified Juvenile Detention Officers.

§343.16. Persons Who Must be Certified.

§343.17. Code of Ethics.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902267
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER C. PRE-ADJUDICATION SECURE DETENTION FACILITY STANDARDS

37 TAC §§343.30 - 343.37

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the

Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

This repeal is proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§343.30. Intake, Admission and Release.

§343.31. Classification Plan.

§343.32. Supervision.

§343.33. Records.

§343.34. Sleeping Units.

§343.35. Multiple Occupancy Sleeping Units.

§343.36. Physical Plant.

§343.37. Programs.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902268
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER D. POST-ADJUDICATION SECURE CORRECTIONAL FACILITY STANDARDS

37 TAC §§343.45 - 343.52

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

This repeal is proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§343.45. Intake, Admission and Release.

§343.46. Classification Plan.

§343.47. Supervision.

§343.48. Records.

§343.49. Sleeping Units.

§343.50. Physical Plant.

§343.51. Rules and Discipline.

§343.52. Programs.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902269
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER E. RESTRAINTS

37 TAC §§343.60 - 343.68

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

This repeal is proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§343.60. Definitions.

§343.61. Requirements.

§343.62. Prohibitions.

§343.63. Documentation.

§343.64. Physical Restraint.

§343.65. Mechanical Restraint.

§343.66. Restraint Chair.

§343.67. Chemical Agents.

§343.68. Transporting Residents Outside Facility.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 424-6710

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CHAPTER 343. SECURE JUVENILE PRE-ADJUDICATION DETENTION AND POST-ADJUDICATION CORRECTIONAL FACILITIES

The Texas Juvenile Probation Commission (TJPC) proposes new Chapter 343, §§343.100, 343.102, 343.104, 343.106, 343.200, 343.202, 343.204, 343.206, 343.208, 343.210, 343.212, 343.214, 343.218, 343.220, 343.222, 343.224, 343.226, 343.228, 343.230, 343.232, 343.234, 343.236, 343.238, 343.240, 343.242, 343.244, 343.246, 343.248 - 343.250, 343.260, 343.262, 343.264, 343.266, 343.268,

343.270, 343.272, 343.274, 343.276, 343.278, 343.280, 343.282, 343.286, 343.288, 343.290, 343.300, 343.302, 343.304, 343.306, 343.308, 343.310, 343.312, 343.314, 343.316, 343.320, 343.322, 343.324, 343.326, 343.328, 343.330, 343.332, 343.334, 343.336, 343.338, 343.340, 343.342, 343.346, 343.348, 343.350, 343.352, 343.354, 343.356, 343.358, 343.360, 343.362, 343.364, 343.366, 343.368, 343.370, 343.372, 343.374, 343.376, 343.378, 343.380, 343.382, 343.384, 343.386, 343.400, 343.402, 343.404, 343.406, 343.408, 343.410, 343.412, 343.414, 343.416, 343.418, 343.420, 343.422, 343.424, 343.426, 343.428, 343.430, 343.432, 343.434, 343.436, 343.438, 343.440, 343.442, 343.444, 343.446, 343.448, 343.450, 343.452, 343.454, 343.456, 343.458, 343.460, 343.462, 343.464, 343.468, 343.470, 343.472, 343.474, 343.476, 343.478, 343.480, 343.482, 343.484, 343.486, 343.488 - 343.494, 343.496, 343.498, 343.600, 343.602, 343.604, 343.606, 343.608, 343.610, 343.612, 343.614, 343.616, 343.618, 343.620, 343.622, 343.624, 343.626, 343.628, 343.630, 343.632, 343.634, 343.636, 343.638, 343.640, 343.642, 343.644, 343.646, 343.648, 343.650, 343.652, 343.654, 343.656, 343.658, 343.660, 343.662, 343.664, 343.666, 343.668, 343.670 - 343.678, 343.680, 343.686, 343.688, 343.690, 343.700, 343.702, 343.704, 343.706, 343.708, 343.710, 343.712, 343.800, 343.802, 343.804, 343.806, 343.808, 343.810, 343.812, 343.816, and 343.818, relating to standards for secure juvenile pre-adjudication detention and post-adjudication correctional facilities. These new standards are being proposed in an effort to ensure that the minimum standards for secure pre- and post-adjudication juvenile facilities reflect practices specific to federal constitutional requirements, relevant federal statutes, and national standards and related best practices models. Additionally, these standards are being proposed to ensure that the Texas Juvenile Probation Commission's related standards monitoring expectations are clearly identified within the context of Administrative Code Rules. These standards were originally published in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2453) and are being withdrawn and republished with substantive changes for another thirty day public comment period.

Lisa A. Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the rules are in effect, there will be limited fiscal implications for state government and local government as a result of enforcement or implementation, including:

Section 343.404. Under this proposed standard, a consultation may result in fiscal implications if assessments or evaluations are recommended by a qualified mental health professional (QMHP) or a mental health professional (MHP). The diversity of the recommendations a QMHP or a MHP may make does not readily lend itself to a reliable cost analysis. There could be a fiscal impact for those jurisdictions that do not have access to a QMHP or that do not employ a MHP. The costs associated with mental health consultations may be offset by the TJPC's $5 million Legislative Appropriations Request (LAR) to assist in funding mental health professionals in all pre- and post-adjudication facilities across the state.

Section 343.406. This proposed standard would require professionally administered health assessments for detainees who are identified (by formalized screening, request, or observation) as having a medical need. Additionally, the standard would require a professionally administered health assessment for youth held in detention for 30 consecutive days that have not already had said assessment completed. The 30-day requirement would only impact a small percentage of the State's annual detention population because the current average length of stay is approximately 13 days. In 2007, approximately 6,300 (11.12%) of the 56,000 plus youth detained were held for 30 days or longer. Of these 6,300 youth, approximately 2,600 were detained in the State's three largest jurisdictions, which had health care professionals actually administering initial screenings or providing standardized follow up (i.e., assessment) of youth soon after admission (both practices would negate the need for 30-day assessments). The remaining 3,700 youth would be further reduced by exempting those with a prior health assessment (up to one year old) provided by an alternative source (e.g., school, parent, prior juvenile justice contact, etc.). The remaining detainees impacted by the proposed standards could be professionally assessed by a licensed nurse for approximately $85.00 per assessment.

Section 343.428 and §343.622. These proposed standards would require that before a juvenile supervision officer (i.e., juvenile detention officer) assumed their standardized supervision duties, an officer would have to complete training in at least 40 hours of designated core topics plus an additional 24 hours of training in restraint technique and basic first aid and CPR. This provision would require at least 64 hours of training before an officer assumed his or her duties. Currently, an officer can assume these duties with approximately 28 to 32 hours of instruction in a restraint technique (approximately 16 hours), first aid and CPR (8 hours combined), abuse and neglect reporting requirements (2-4 hours), and facility-specific resident suicide prevention policies (2-4 hours). Therefore, the required training hours (and potential associated costs) could increase by approximately 44%. The TJPC has increased the availability of web-based training seminars to help offset increased training requirements.

Section 343.812. There are multiple provisions within this proposed standard that may have a fiscal impact on those select secure facilities that utilize non-ambulatory restraints. It is important to note that use of non-ambulatory restraint devices is not required per TJPC standards. Therefore, the following fiscal impact summaries would be applicable only to those jurisdictions that decide to incorporate non-ambulatory restraints. Subsection (d) of this section would restrict resident rooms with fixed restraint apparatus from housing ineligible youth (those not subject to non-ambulatory restraint) or require that static restraint fixtures within the unit be removed or defeated. Subsection (e) of this section would prohibit jurisdictions from fabricating their own non-ambulatory restraint devices and require they purchase professionally manufactured and commercially available devices instead. The TJPC's research indicates that a professionally manufactured and commercially available restraint bed (with all necessary attachments) could cost anywhere from approximately $1,400.00 to $2,700.00 per unit. Subsection (f) of this section would require that non-ambulatory restraints lasting longer than one hour in duration are accompanied by the relevant recommendations submitted by a health care professional or a mental health professional. And finally, subsection (i) of this section requires that youth in non-ambulatory restraints be provided constant visual supervision by a juvenile supervision officer (i.e., detention officer). This may then require the allocation of additional JSOs.

Ms. Capers has also determined that for each year of the first five years the new rules are in effect, the public benefit expected as a result of enforcement or implementation will be the im-

proved conditions of confinement for youth incarcerated in the State's secure pre- and post-adjudication juvenile facilities and enhanced training credentials for the direct care staff serving and supervising these youth. There will be no impact on small business or individuals as a result of the amendments.

Public comments on the proposed rules may be submitted in writing to Diane Laffoon at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547. Comments may also be submitted electronically to *Diane.Laffoon@tjpc.state.tx.us* or faxed to (512) 424-6718.

SUBCHAPTER A. DEFINITIONS AND APPLICABILITY

37 TAC §§343.100, 343.102, 343.104, 343.106

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new chapter.

§343.100. Definitions.

The following words and terms when used in this chapter shall have the following meanings, unless otherwise expressly defined within the chapter.

(1) Behavioral Health Assessment--A mental health assessment conducted by a Masters-level mental health professional with Texas State licensure (i.e., LPC, LMFT and LCSW) or a mental health paraprofessional that includes information from testing, review of background information and clinical interview(s). See the Commission's commentary of §343.600 of this chapter for a complete listing of the specific elements required to be addressed in this assessment.

(2) Chief Administrative Officer--Regardless of title, the person hired by a juvenile board who is responsible for oversight of the day-to-day operations of a juvenile probation department for a single county or a multi-county judicial district.

(3) Commission--The Texas Juvenile Probation Commission (TJPC).

(4) Common Activity Area--Area inside the facility to which residents have access and in which activities are conducted. This area includes, but is not limited to dayrooms, covered recreation areas, recreation rooms, education rooms, counseling rooms, testing rooms, visitation areas, and medical or dental rooms.

(5) Contraband--Any item not issued to employees for the performance of their duties and which employees have not obtained supervisory approval to possess. Contraband also includes any item given to a resident by an employee or other individual, which a resident is not authorized to possess or use. Specific items of contraband include, but are not limited to:

(A) firearms;

(B) knives;

(C) ammunition;

(D) drugs;

(E) intoxicants;

(F) pornography; and

(G) any unauthorized written or verbal communication brought into or taken from an institution for a resident, former resident, associate of or family members of a resident.

(6) Date and Time of Admission--The date and time a juvenile has been authorized for detention in a secure pre-adjudication detention facility by an individual who is authorized by the juvenile board in accordance with §53.02 of the Texas Family Code. If the decision to detain was made prior to the juvenile's arrival to the facility, the date and time of admission shall be the same as the date and time of entry.

(7) Date and Time of Entry--The date and time a juvenile has been presented by law enforcement or county juvenile probation officer to a pre-adjudication secure detention facility for processing and authorization of detention.

(8) Design Capacity--The number of people that can safely occupy a building or space as determined by the current architectural design and any building modifications, licensing, accreditation, regulatory authorities, and applicable building codes.

(9) Designee--The person authorized to perform a specific duty as assigned by the facility administrator.

(10) Detention--The temporary secure custody of a child as defined in and authorized by Title 3 of the Texas Family Code.

(11) Disciplinary Seclusion--The separation of a resident from other residents for disciplinary reasons, and the placement of the resident alone in an area from which egress is prevented for more than 90 minutes.

(12) Facility Administrator--The individual designated by the chief administrative officer or governing board of the facility who has the ultimate responsibility for managing and operating the facility. This definition includes the certified juvenile supervision officer who is designated in writing as the acting facility administrator during the absence of the facility administrator.

(13) Furlough--A period of time during which a resident is allowed to leave the facility premises and go into the community unsupervised for various purposes consistent with public interest.

(14) Hazardous Material--Any substance which is explosive, flammable, combustible, poisonous, corrosive, irritating or otherwise harmful and is likely to cause injury or death.

(15) Health Administrator--A person, who by virtue of education, experience or certification (e.g., MSN, MPH, MHA, FACHE, CCHP, MD, DO), is capable of assuming responsibility for arranging all levels of health care and ensuring quality and accessible health services for juveniles.

(16) Health Assessment--The process whereby the health status of an individual is evaluated, which may include questioning the patient regarding symptoms.

(17) Health Care Professional--A term that includes physicians, physician assistants, nurses, nurse practitioners, dentists, medical and nursing care assistants, emergency medical technicians (EMT), and others who, by virtue of their education, credentials and experience, are permitted by law to evaluate and care for patients.

(18) Health Service Authority--The agency, organization, entity or individual responsible for consulting and collaborating with the facility administrator and/or the health services coordinator to ensure a coordinated and adequate health care system is available to residents of the facility.

(19) Housing Area--An area within a secure juvenile facility that contains any single occupancy housing unit or units (SOHU) and/or multiple occupancy housing unit or units (MOHU).

(20) Housing Unit--A unit within the housing area that may be designed and constructed as either a single occupancy housing unit (SOHU) or a multiple occupancy housing unit (MOHU).

(21) Individual Resident Sleeping Quarter--A cell or room designed and constructed to securely house one resident.

(22) Intra-Jurisdictional Custodial Transfer--The transfer of a resident from a pre-adjudication secure detention facility into a post-adjudication secure correctional facility under the same administrative authority.

(23) Isolation--The separation of a resident from other residents and the placement of the resident alone in an area from which egress is prevented for assessment, medical, or protective purposes.

(24) Juvenile--A person who is under the jurisdiction of the juvenile court, confined in a juvenile justice facility, or participating in a juvenile justice program administered or operated under the authority of the juvenile board.

(25) Juvenile Supervision Officer--A person whose primary responsibility and essential function is the supervision of juveniles in a juvenile justice facility or a juvenile justice program operated by or under contract with the juvenile board.

(26) Material Safety Data Sheet (MSDS)--A document prepared by the supplier or manufacturer of a product clearly stating its hazardous nature, ingredients, precautions to follow, health effects and safe handling/storage information.

(27) Medical Entity--An agency or organization that is primarily composed of health care professionals.

(28) Medical Treatment--Medical care, including diagnostic testing (e.g., x-rays, laboratory testing, etc.), performed or ordered by a physician, physician assistant, licensed nurse practitioner, emergency medical technician (EMT), or paramedic.

(29) Mental Health Paraprofessional--An individual who is able to perform tasks requiring significant knowledge, but without having the license or certification to perform at a professional level, including students, interns, fellows, post-doctorates, or other approved students in an official training program in psychology or a related field under the supervision of an authorized mental health professional.

(30) Mental Health Professional--An individual who has met the educational requirements and is licensed or certified by one or more of the following governmental entities:

(A) the Texas State Board of Examiners of Psychologists;

(B) the Texas State Board of Examiners of Professional Counselors;

(C) the Texas State Board of Examiners of Marriage and Family Therapists;

(D) the Texas Department of State Health Services;

(E) the Texas Medical Board;

(F) the Texas State Board of Social Worker Examiners provided that the licensure is Licensed Clinical Social Work; or

(G) the Texas State Board of Social Worker Examiners provided that the licensure is Licensed Master Social Work accompanied with written recognition by the board for independent practice.

(31) Mental Health Screening--A process that includes a series of questions that are designed to identify a resident who is at an increased risk of having mental health disorders that warrant attention and a professional review.

(32) Military-Style Program--A program or component in a post-adjudication secure correctional facility for juvenile offenders that features military-style discipline and structure as an integral part of its treatment and rehabilitation program.

(33) Multiple Occupancy Housing Unit (MOHU)--A housing unit designed and constructed for multiple occupancy sleeping which is self-contained and includes appropriate sleeping, sanitation, and hygiene equipment or fixtures.

(34) Non-Program Hours--Time period when all scheduled resident activity for the entire resident population in the facility has ceased for the day.

(35) Physical Training Program--Any program that requires participants to engage in and perform structured physical training and activity. This does not include recreational team activities or activities related to the educational curriculum (i.e., physical education).

(36) Positive Screening--A scored result of a completed mental health screening instrument (i.e., MAYSI-2) recommending services requiring a primary service by a mental health professional as described on the MAYSI-2 reference card.

(37) Post-Adjudication Secure Correctional Facility ("Facility" or "Secure Facility")--A secure facility administered by a governing board that includes construction and fixtures designed to physically restrict the movements and activities of the residents and is intended for the treatment and rehabilitation of youth who have been adjudicated. Subchapters A, B, D and E of this chapter apply to all post-adjudication secure correctional facilities. A post-adjudication secure correctional facility does not include any non-secure residential program operating under the authority of a governing board.

(38) Pre-Adjudication Secure Detention Facility ("Facility" or "Secure Facility")--A secure facility administered by a governing board that includes construction and fixtures designed to physically restrict the movements and activities of juveniles or other individuals held in lawful custody in the facility and is used for the temporary placement of any juvenile or other individual who is accused of having committed an offense and is awaiting court action, an administrative hearing, or other transfer action. Subchapters A, B, C and E of this chapter apply to all pre-adjudication secure detention facilities. A pre-adjudication secure detention facility does not include a short-term detention facility as defined by §51.12(j) of the Texas Family Code.

(39) Premises--A building(s) together with its grounds or other appurtenances.

(40) Primary Control Room--A restricted or secure area from which entrance into and exit from a secure facility is controlled. The primary control room also contains the emergency, monitoring, and communications systems and is staffed 24 hours each day that residents are in the facility.

(41) Professionals--The following persons are considered professionals for limited purposes:

(A) teachers certified as educators by the State Board for Educator Certification including teachers certified by the State Board for Educator Certification with provisional or emergency certifications;

(B) educational aides or paraprofessionals certified by the State Board for Educator Certification;

(C) health care professionals licensed or certified by:

(i) the Texas Board of Nursing;

(ii) the Texas Medical Board;

(iii) the Texas Physician Assistant Board;

(iv) the Texas Department of State Health Services; or

(v) the State Board of Dental Examiners;

(D) mental health professionals as defined herein;

(E) qualified mental health professional as defined herein;

(F) mental health paraprofessional as defined herein;

(G) social workers licensed by the Texas Board of Social Worker Examiners;

(H) juvenile probation officers certified by the Texas Juvenile Probation Commission; and

(I) commissioned law enforcement personnel.

(42) Protective Isolation--The exclusion of the threatened resident from the group by placing the resident in an individual room that minimizes contact with the residents from a specific group.

(43) Program Hours--Time period of no less than ten hours when the resident population has scheduled activities and any shift changes that occur during the time period when the resident population has scheduled activities.

(44) Qualified Mental Health Professional--An individual employed by the local mental health authority or an entity who contracts as a service provider with the local mental health authority who meets the guidelines of the Texas Department of State Health Services.

(45) Rated Capacity--The maximum number of beds available in a facility that were architecturally designed as a housing unit.

(46) Resident--A juvenile or other individual that has been lawfully admitted into a juvenile pre-adjudication secure detention facility or a post-adjudication secure correctional facility.

(47) Room Restriction--The separation of a resident from other residents for behavior modification, and the placement of the resident alone in an area from which egress is prevented for 90 minutes or less.

(48) Secondary Screening--A triage process that is brief and designed to clarify if a resident is in need of intervention or a more comprehensive assessment and what type of intervention or assessment is needed.

(49) Serious Mental Illness--A professional diagnosis of the following disorders: psychoses, schizophrenia, bipolar with psychotic features, depression with psychotic features, severe post-traumatic stress disorder, and schizoaffective disorders.

(50) Single Occupancy Housing Unit (SOHU)--A housing unit designed and constructed with separate and secure individual resident sleeping quarters and includes appropriate sleeping, sanitation, and hygiene equipment or fixtures.

(51) Standard Screening Instrument--An instrument approved by the Commission that screens the juvenile's needs in the area of mental health.

(52) Volunteer--Individuals agreeing to perform services without compensation, who have regular or periodic supervised contact or unsupervised contact with juveniles under the direction of the pre-adjudication and post-adjudication secure juvenile facility.

(53) Youth-on-Youth Sexual Conduct--Two or more juveniles, regardless of age, who engage in deviate sexual intercourse, sexual contact, sexual intercourse, or sexual performance as those terms are defined herein:

(A) "Deviate sexual intercourse" means:

(i) any contact between any part of the genitals of one person and the mouth or anus of another person; or

(ii) the penetration of the genitals or the anus of another person with an object.

(B) "Sexual contact" means the following acts, if committed with the intent to arouse or gratify the sexual desire of any person:

(i) any touching by a person, including touching through clothing, of the anus, breast, or any part of the genitals of a person; or

(ii) any touching of any part of the body of a person, including touching through clothing, with the anus, breast, or any part of the genitals of a person.

(C) "Sexual intercourse" means any penetration of the female sex organ by the male sex organ.

(D) "Sexual performance" means acts of a sexual or suggestive nature performed in front of one or more persons, including simulated or actual sexual intercourse, deviate sexual intercourse, sexual bestiality, masturbation, sado-masochistic abuse or lewd exhibition of the genitals, the anus, or any portion of the female breast below the top of the areola.

(E) A juvenile may not consent to the acts as defined herein under any circumstances. Consent may not be implied regardless of the age of the juvenile.

§343.102. Interpretation and Applicability.

(a) Headings. The headings in this chapter are for convenience only and are not intended as a guide to the interpretation of the standards herein.

(b) Including. The word "including", when following a general statement or term, is not to be construed as limiting the general statement or term to any specific item or manner set forth or to similar items or matters, but, rather, as permitting the general statement or term to refer also to all other items or matters that could reasonably fall within its broadest possible scope.

(c) Applicability. This chapter applies to all secure juvenile pre-adjudication detention facilities and post-adjudication correctional facilities in this State, except for a facility operated or certified by the Texas Youth Commission. This chapter does not apply to a facility that is licensed by a state governmental entity or that is exempt from licensure by state or federal law. Furthermore, all standards requiring written policies and procedures are expected to be implemented and practiced.

(d) Compliance Resource Manual and Implementation of Agency Policy. The Commission may establish by administrative rule or other reasonable agency policy, the required guidelines, procedures, and documentation necessary to ensure compliance and verification of the standards set forth in this chapter.

§343.104. Waiver.

Unless expressly prohibited by another standard, the governing board, the chief administrative officer, or facility administrator may make an application for waiver of any standard or standards adopted by the Commission in accordance with Chapter 349 of this title.

§343.106. Variance.

Unless expressly prohibited by another standard, the juvenile board may make an application for variance of any standard or standards adopted by the Commission in accordance with §349.2 of this title.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TRD-200902241
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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SUBCHAPTER B. PRE-ADJUDICATION AND POST-ADJUDICATION SECURE FACILITY STANDARDS

37 TAC §§343.200, 343.202, 343.204, 343.206, 343.208, 343.210, 343.212, 343.214, 343.218, 343.220, 343.222, 343.224, 343.226, 343.228, 343.230, 343.232, 343.234, 343.236, 343.238, 343.240, 343.242, 343.244, 343.246, 343.248 - 343.250, 343.260, 343.262, 343.264, 343.266, 343.268, 343.270, 343.272, 343.274, 343.276, 343.278, 343.280, 343.282, 343.286, 343.288, 343.290, 343.300, 343.302, 343.304, 343.306, 343.308, 343.310, 343.312, 343.314, 343.316, 343.320, 343.322, 343.324, 343.326, 343.328, 343.330, 343.332, 343.334, 343.336, 343.338, 343.340, 343.342, 343.346, 343.348, 343.350, 343.352, 343.354, 343.356, 343.358, 343.360, 343.362, 343.364, 343.366, 343.368, 343.370, 343.372, 343.374, 343.376, 343.378, 343.380, 343.382, 343.384, 343.386

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new chapter.

§343.200. Authority to Operate Secure Juvenile Facility.

Pursuant to Texas Family Code Title 3, a pre-adjudication secure detention facility and a post-adjudication secure correctional facility for juvenile offenders may only be operated by:

(1) a governmental unit in this State; or

(2) a private entity under a contract with a governmental unit in this State.

§343.202. Acceptance of Residents.

A facility may only accept and admit a child, as that term is defined in §51.02(2) of the Texas Family Code, who:

(1) has been charged with or adjudicated of an offense or offenses against the laws of this State;

(2) is authorized to be detained or confined pursuant to Title 3 of the Texas Family Code; or

(3) is a juvenile adjudicated of offenses committed against the laws of another state or the United States whose confinement is authorized pursuant to Chapter 342 of this title.

§343.204. Facility Governing Board.

Each facility shall have a governing board that functions in an oversight capacity to the facility. The governing board shall be a governmental unit or a board of trustees appointed by the governmental unit that establishes and operates or contracts for the establishment and operation of the facility. The governing board for the facility shall provide oversight of facility operations, policies and procedures.

§343.206. Certification and Registration of Facility.

Before admitting residents, the juvenile board in the county where the facility is located, shall:

(1) certify the facility in compliance with §51.12 or §51.125 of the Texas Family Code;

(2) designate the number of pre-adjudication and post-adjudication beds in the facility certification;

(3) register the facility with the Commission in compliance with §51.12 or §51.125 of the Texas Family Code; and

(4) post within a public area of the facility the current facility certification and the Commission's facility registration.

§343.208. Policy, Procedure, and Practice.

The governing board of the facility shall require that written policies and procedures exist governing the operation of all secure juvenile pre-adjudication detention and post-adjudication correctional facilities in the county. The policies, procedures, and practices of the facility shall include:

(1) a policy in the following areas strictly prohibiting:

(A) physical, sexual or emotional abuse, neglect or exploitation of a resident by any individual having contact with a resident of the facility;

(B) youth-on-youth sexual conduct between residents;

(C) violations of the juvenile supervision officer code of ethics and code of conduct as outlined in Chapter 341 of this title;

(D) violations of any professional code of ethics or conduct by any individual providing services to or having contact with residents of the facility; and

(2) a zero tolerance policy and practice regarding sexual abuse in accordance with the Prison Rape Elimination Act of 2003 that provides for administrative and/or criminal disciplinary sanctions.

§343.210. Designation and Qualifications of Facility Administrator.

(a) The chief administrative officer or the governing board of the facility or their designee shall designate a single facility administrator for each secure facility.

(b) The facility administrator shall:

(1) have acquired a bachelor degree conferred by a college or university accredited by an accrediting organization recognized by the Texas Higher Education Coordinating Board;

(2) have either:

(A) one year of graduate study in criminology, corrections, counseling, law, social work, psychology, sociology, or other field of instruction approved by the Commission; or

(B) one year of experience in full-time case work, counseling, or community or group work:

(i) in a social service, community, corrections, or juvenile agency that deals with offenders or disadvantaged persons; and

(ii) the Commission determines the kind of experience necessary to meet this requirement; and

(3) maintain an active Commission certification as a juvenile supervision officer.

§343.212. Duties of Facility Administrator.

(a) The facility administrator shall be responsible for the daily operations of the facility and shall maintain an office at the facility.

(b) The facility administrator shall designate a certified juvenile supervision officer to be in charge during his or her absence from the facility.

(c) The facility administrator shall develop, implement and maintain a policies and procedures manual for the facility and shall ensure the daily facility practice conforms to the policies and procedures detailed in the manual.

(d) The facility administrator shall review the facility's policies and procedures manual at least every 365 calendar days and maintain documentation of this review.

(e) The facility administrator shall make available the policies and procedures manual to all employees of the facility.

(f) The facility administrator shall ensure that all employees of the facility are:

(1) trained on the policies and procedures manual provisions relevant to the employee's job functions during new employee orientation or prior to beginning service at the facility and maintain documentation of that training; and

(2) provided or made available, in a written or electronic format, all changes or modifications to the policies and procedures manual in a timely manner.

(g) The facility administrator or designee shall ensure that current, accurate and confidential personnel records are maintained for each employee which shall include:

(1) proof of age;

(2) documentation of criminal background checks conducted as required by this title;

(3) the completed application for employment;

(4) training records; and

(5) documentation of promotion, demotion, termination and other personnel actions.

(h) The facility administrator or chief administrative officer shall provide the presiding officer of the juvenile board or governing board of the facility with periodic updates on the operation of the facility, including the following information to be provided at least every quarter:

(1) facility population/capacity reports;

(2) number of serious incidents by category that occurred in the facility;

(3) number of resident restraints by type (e.g., personal, mechanical and chemical);

(4) number of injuries to residents requiring medical treatment; and

(5) number of injuries to staff requiring medical treatment.

(i) The facility administrator or chief administrative officer shall ensure the accurate and timely submission of statistical data to the Commission in an electronic format or other format as requested by the Commission.

(j) The facility administrator or chief administrative officer shall ensure that all individuals employed by the facility who have unsupervised contact with residents are subjected to all required criminal history background checks as required by Chapter 344 of this title.

§343.214. Data Collection.

The facility administrator or chief administrative officer shall maintain and report to the Commission electronically, or in the format requested, accurate statistics in the following areas:

(1) total number of grievances;

(2) total number of personal restraint incidents;

(3) total number of mechanical restraint incidents;

(4) total number of chemical restraint incidents;

(5) total number of non-ambulatory restraint incidents;

(6) total number of disciplinary seclusions; and

(7) total number of detention staff injuries resulting from interaction with residents.

§343.218. Location and Operations.

(a) Co-located Facilities.

(1) If the facility is located in the same building or on the grounds of any type of adult corrections facility, it shall be a separate, self-contained unit.

(2) All applicable federal and state laws pertaining to the separation of juveniles from adult inmates shall apply.

(3) The facility shall submit information and agree to monitoring from the Office of the Governor and/or the contract representative.

(b) Separate Operations.

(1) All pre-adjudication programs shall be operated separately from any post-adjudication programs.

(2) Where a pre-adjudication program and a post-adjudication program are located in the same building or on the same grounds, contact between the two populations shall be kept to a minimum.

(c) Non-Secure Programming on Facility Premises. Any youths who participate in day programming on the facility premise who are not residents of the facility shall be kept physically separated from residents of the facility at all times.

§343.220. Population.

The population of the facility shall not exceed the rated capacity of the facility.

§343.222. Heating and Ventilation.

(a) The facility shall provide fully functioning heating, cooling and ventilation systems adequate for the square footage of the facility.

(b) Alternate means of ventilation in the facility shall be maintained in case regular power is interrupted.

§343.224. Alternate Power Source.

(a) The facility shall have an alternate source(s) of electrical power that provides for the simultaneous operations of life safety systems including:

(1) emergency lighting;

(2) illuminated emergency exit lights and signs;

(3) emergency audible communication systems and equipment;

(4) fire detection and alarm systems;

(5) ventilation and smoke management systems; and

(6) all secure door locking mechanisms which operate exclusively on electric current.

(b) The alternate power source system shall be tested at least every 15 calendar days to ensure the system is in working condition.

(c) The alternate power system (e.g., the alternate power source and the life safety systems required to be operated) shall be inspected at least every 365 calendar days. This inspection must be completed by a person with qualifications established through work experience, relevant training, specialized licensure or certification.

(d) All of the aforementioned tests shall be documented to minimally include test date and test results.

(e) Any system malfunctions or maintenance needs that are identified during a test, or at any other time, shall require that a written maintenance request be immediately submitted to the appropriate personnel.

§343.226. Lighting.

(a) Lighting. Adequate lighting shall be provided to all areas of the facility.

(b) Natural Lighting. All housing units shall provide natural light available from a source within the housing unit. This standard also applies to all specialized housing.

§343.228. Dining Area.

The dining area shall provide a minimum of 15 square feet of floor space per diner.

§343.230. Specialized Housing.

Any room utilized for the disciplinary seclusion, protective isolation, assessment isolation, or medical isolation of residents from the general population during program hours shall be equipped with:

(1) an operable toilet above floor level;

(2) a washbasin with hot and cold running water; and

(3) a bed above floor level.

§343.232. Housing for Residents with Physical Disabilities.

All housing areas used by residents with a physical disability shall be designed for their use and provide for their safety and security in accordance with state and federal law.

§343.234. Program Areas.

The facility shall provide space for:

(1) visitation;

(2) religious activities;

(3) interviewing and counseling; and

(4) educational instruction.

§343.236. Secure Storage Areas.

(a) Cleaning Supplies. Storage of cleaning supplies and equipment shall be locked and not accessible to residents.

(b) Restraint Devices. There shall be a location for secure storage of restraining devices and related security equipment. This equipment shall be readily accessible to authorized persons.

(c) Personal Property. Space shall be provided for secure storage of the resident's personal property.

§343.238. Hazardous Materials.

(a) The facility shall maintain an inventory and a copy of the Material Safety Data Sheet (MSDS) for all hazardous materials located in the facility.

(b) The facility shall prohibit the use of all hazardous materials by residents.

(c) Exceptions. Materials manufactured specifically for cleaning purposes may be used by residents for cleaning areas of the facility under the constant supervision of the juvenile supervision officer. The resident must be provided instruction on the use of the hazardous material and the proper equipment as prescribed by the MSDS.

(d) Any use of hazardous materials shall be used according to the manufacturer's instructions.

§343.240. Safety Codes.

(a) The facility shall conform to the provisions set forth in the Life Safety Code, National Fire Protection Association (NFPA) 101 and/or any applicable state and local fire safety codes. The Life Safety Code may be substituted with local government ordinances or codes only if said ordinances or codes are specifically written to include building occupancy for detention and correctional usage.

(b) A formalized Life Safety Code/fire safety inspection shall be completed prior to the facility becoming operational.

(c) All subsequent Life Safety Code/fire safety inspections shall be conducted no later than 365 calendar days from the date of previous inspection.

(d) Each Life Safety Code/fire safety inspection shall result in a written report that minimally contains the following information:

(1) the identification of the specific code(s) used to complete the inspection. The code(s) in question will either be the NFPAs Life Safety Code 101 or the applicable state, municipal, or county specific fire code adopted by the jurisdiction;

(2) the name of the governmental entity that conducted the inspection;

(3) the identification of any applicable code violations or infractions and the corresponding corrective action requirements;

(4) the name and title of the person conducting the inspection; and

(5) the date(s) of the inspection.

(e) Any deficiencies noted in the annual inspection report shall be immediately addressed by the facility administrator or designee. The facility administrator shall develop and document a corrective action plan to rectify all deficiencies.

§343.242. Fire Safety Plan.

(a) The facility shall have in effect and available to all supervisory personnel, written copies of a fire safety plan for the protection of

all persons in the event of a fire for their evacuation to areas of refuge and for their evacuation from the building if necessary.

(b) The fire safety plan shall be coordinated with and reviewed by the fire department whose jurisdiction includes the facility. The coordination and review efforts required in this standard shall be validated by written documentation prepared or attested to by a representative of the applicable fire department.

(c) The fire safety plan shall require that all employees be instructed to ensure the following:

(1) proper disposal of combustible refuse;

(2) prompt evacuation of the facility; and

(3) procedures for the use and control of flammable, toxic, and caustic materials.

§343.244. Fire Safety Officer.

The fire safety officer shall:

(1) ensure maintenance of a current fire drill log;

(2) ensure that fire drills are conducted as required by §343.246 of this chapter;

(3) ensure the posting of a plan for prompt evacuation of the facility as required by §343.246 of this chapter;

(4) implement procedures for proper disposal of combustible refuse; and

(5) implement procedures for the use and control of flammable, toxic, and caustic materials.

§343.246. Fire Drills.

(a) Required Fire Drills. The fire safety officer or designee shall conduct fire drills on all shifts at least every 90 calendar days.

(b) All staff on duty in the facility shall participate in the fire drills.

(c) Exits. Facility exits shall be clear of obstruction and properly marked for evacuation in the event of fire or emergencies.

(d) Evacuation Plans. Facility emergency evacuation plans shall be posted in resident restricted areas.

§343.248. Non-Fire Emergency Preparedness Plan.

The facility shall have an emergency preparedness plan that includes, but is not limited to severe weather, natural disasters, disturbances or riots, national security issues, and medical emergencies. The plan shall address:

(1) the identification of key personnel and their specific responsibilities during an emergency or disaster situation;

(2) agreements with other agencies or departments; and

(3) transportation to pre-determined evacuation sites.

§343.249. Internal Security.

(a) Policies and Procedures. Written policies and procedures for security and control of the facility shall include the following:

(1) continued operations in the event of a work stoppage;

(2) key control;

(3) control of the use of:

(A) tools;

(B) medical equipment; and

(C) kitchen tools;

(4) provisions to prevent firearms from entering the secure area of the facility; and

(5) provisions for coordination with law enforcement authorities in the case of escape or other situations requiring assistance from city, county or state law enforcement agencies.

(b) Documentation.

(1) The facility administrator or designee shall ensure the documentation of all special incidents, including, but not limited to the taking of hostages, escapes, and assaults.

(2) A copy of the report shall be placed in the permanent file of any resident(s) involved in the incident.

(c) Video and Audio Surveillance. Video and audio monitoring devices may be utilized for security purposes but shall not substitute for required levels of supervision by a juvenile supervision officer.

§343.250. External and Perimeter Security.

(a) The facility shall be constructed so that residents remain within the premises and the general public is denied access without authorization.

(b) Perimeter security shall be maintained at all times. Any outdoor area in which residents are permitted shall be enclosed by a permanently erected fence or wall to help prevent resident escapes and unauthorized public entry to the facility grounds.

§343.260. Resident Searches.

(a) Residents shall only be subjected to the following searches:

(1) a pat down or frisk search as necessary for facility security and safety;

(2) an oral cavity search to prevent concealment of contraband, to ensure the proper administration of medication;

(3) a strip search in which the resident is required to surrender their clothing based on the reasonable belief that the resident is in possession of contraband or if there is reasonable belief that the resident presents a threat to the facility's safety and security;

(A) a strip search shall be limited to a visual observation of the resident and shall not involve the physical touching of a resident;

(B) a strip search shall be performed in an area that ensures the privacy and dignity of the resident; and

(C) a strip search shall be conducted by a staff member of the same gender as the resident being searched;

(4) an anal or genital body cavity search only if there is probable cause to believe that they are concealing contraband;

(A) an anal or genital body cavity search shall be conducted only by a physician. The physician shall be of the same gender as the resident, if available; and

(B) all anal and genital body cavity searches shall be conducted in an office or room designated for medical procedures; and

(C) all anal and genital body cavity searches shall be documented with the documentation being maintained in the resident's file.

(b) During searches, the residents shall not be touched any more than necessary to conduct a comprehensive search; and

(c) Every effort shall be made to prevent embarrassment or humiliation of the resident.

§343.262. Hygiene Plan.

Residents shall be given appropriate instruction on personal and oral hygiene and shall be provided the necessary articles to maintain proper personal cleanliness.

§343.264. Personal Hygiene.

Residents shall be provided the opportunity to shower daily or after participating in strenuous exercise.

§343.266. Bedding.

(a) Each resident shall be provided suitable clean bedding, including two sheets, a pillow and a pillowcase, a mattress, and a blanket. Mattresses with an integrated pillow may be substituted for a separate pillow and a pillowcase.

(b) Clean bed linens shall be issued at least every seven calendar days.

(c) Modifications to a resident's bedding items may be made in accordance with §343.340(a)(8) of this chapter.

(d) In no case, shall residents on suicide supervision be denied appropriate bedding substitutions.

(e) If the resident has demonstrated a pattern of misuse of bed linens or if staff have reason to believe the resident will misuse the bed linens, which includes but is not limited to using the sheets as a weapon, the sheets may be substituted with a blanket.

§343.268. Towels.

A clean towel shall be issued to each resident daily.

§343.270. Clothing.

(a) Clean clothing shall be provided to each resident upon admission into the facility.

(b) Clean and disinfected undergarments and socks shall be issued daily and other clean clothing shall be issued at least twice per week.

(c) Climate appropriate clothing shall be provided to all residents in the facility for any outdoor programming or activities.

(d) A resident on suicide supervision status may have their clothing requirements modified per the facility's suicide prevention plan in §343.340 of this chapter. However, in no case, shall residents on suicide supervision be left in an unnecessary state of undress.

§343.272. Housekeeping Plan.

A written housekeeping plan shall be followed which promotes and ensures cleanliness, facility sanitation, and control of vermin and pests.

§343.274. Resident Discipline Plan.

Each facility shall develop and implement a written resident discipline plan that provides for the fair and consistent application of resident rules and sanctions. A resident discipline plan shall minimally include:

(1) resident rule violations categorized into minor infractions and major violations as well as the corresponding sanctions available to staff. Minor infractions shall be limited to those rules which do not represent serious behavior against persons or property and behavior that does not pose a serious threat to institutional order and safety. Major violations shall be limited to those rules which constitute serious behavior against persons or property and behavior that poses a serious threat to institutional order and safety;

(2) provisions to ensure that rule infractions or resident behaviors which constitute probable cause for an offense of a class B misdemeanor or above shall be referred to the law enforcement agency with applicable jurisdiction for possible investigation and/or prosecution;

(3) a listing of prohibited sanctions for residents that minimally includes:

(A) corporal punishment;

(B) humiliating punishment including verbal harassment of a sexual nature or that relates to a resident's sexual orientation or gender identity;

(C) allowing or directing one resident to sanction another;

(D) group punishment for the acts of individuals;

(E) deprivation or modification of required meals and snacks;

(F) deprivation of clean and appropriate clothing;

(G) deprivation or intentional disruption of scheduled sleeping opportunities;

(H) deprivation or intentional delay of medical and mental health services; and

(I) physical exercises imposed for the purposes of compliance, intimidation, or discipline with the exception of practices allowed in §343.710 of this chapter;

(4) provisions that a resident shall be provided written notice of the alleged major rule violation against him or her no more than 24 hours after the violation;

(5) provisions for an informal process for residents to resolve conflict with rule infractions and the corresponding sanctions, if the facility chooses to employ such a process; this shall include established guidelines that provide instruction for residents and staff in using this informal process to review and resolve resident concerns. In no case, shall a resident be sanctioned or retaliated against for electing to forego the informal disciplinary review process when they are eligible for formal disciplinary reviews;

(6) provisions for disciplinary reviews for major rule violations, including established requirements of when to initiate formal disciplinary reviews and any ensuing appeals. The facility's policies and procedures shall not deny or restrict a formalized disciplinary review or appeal when one is requested by a resident with eligible standing; and

(7) provisions for the administrative review and closure of formal disciplinary reviews that are not disposed of prior to a resident's discharge from the facility.

§343.276. Formal Disciplinary Reviews for Major Rule Violations.

Residents that receive a major rule violation or sanction are eligible to request a formal disciplinary review. Upon such a request, a resident shall receive a formal disciplinary review within ten calendar days.

§343.278. Disciplinary Reviews for Residents in Disciplinary Seclusion.

(a) Residents in disciplinary seclusion shall receive the following due process reviews during the period of their seclusion. The reviews in paragraphs (1) and (2) of this subsection shall be conducted in a face-to-face setting by supervisory-level staff which shall not include any staff member involved in the alleged rule violation or the imposed sanction(s). Each of these two review procedures shall be appropriately documented and the corresponding documentation shall be retained in the resident's file. The following procedures shall be conducted:

(1) If a resident is secluded for at least 24 hours, then the resident shall receive an informal disciplinary review which includes an overview of the facility's formal disciplinary review process. If the 24th hour of seclusion occurs during non-program hours, then the informal review shall be conducted no later than two hours after the start of ensuing day's program hour schedule.

(2) A resident assigned to an extended period of seclusion beyond 24 hours shall have a formal disciplinary review no later than his or her 72nd hour of seclusion per §343.280 of this chapter. If the 72nd hour of seclusion occurs during non-program hours, then the formal disciplinary review shall be conducted no later than two hours after the start of the ensuing day's program hour schedule.

(b) A resident may choose to waive the right to a disciplinary review provided proper notification is given prior to the signing of the waiver. The waiver shall include the applicable rule violation and sanction plan.

§343.280. Formal Disciplinary Review Process.

The formal disciplinary review process shall, at a minimum, adhere to the following requirements:

(1) Disciplinary reviews must be before a neutral and impartial person or board that shall not include any staff member directly involved in either the alleged rule violation or the imposed sanction.

(2) Provisions shall be made for the disclosure of the evidence against the resident accused with a rule violation on his or her behalf.

(3) A resident shall have the opportunity to be heard in person and to present evidence on his or her behalf.

(4) A resident shall have the opportunity to request relevant witnesses on his or her behalf.

(5) A resident shall have the opportunity to secure the aid of a staff member if the resident is illiterate, disabled, or otherwise unable to understand the nature of the proceedings.

(6) If the disciplinary review determines that the resident did not commit a rule violation or that the corresponding sanction was inappropriate, facility staff shall restore or reinstate any denied or modified resident privileges.

(7) At the conclusion of a disciplinary review, a written statement by the individual who conducted the disciplinary review or disciplinary board shall be prepared indicating the evidence relied upon and justification for the disposition. The statement shall be made available to the resident for review and a copy shall be retained in the resident's file.

§343.282. Resident Appeals.

A resident may appeal the findings of a disciplinary review. The facility's resident discipline plan shall minimally include:

(1) provisions for a documented appeals process before a neutral and impartial person or persons not a member of the disciplinary board. The appeals process shall afford each of the due process provisions enumerated in §343.280(2) - (7) of this chapter;

(2) provisions that require the resident to submit the request for an appeal no later than seven calendar days after a disposition is rendered in the disciplinary review;

(3) provisions that require the resident's appeal to be heard within 30 calendar days of resident's request; and

(4) provisions for a written statement by the appeals officer or appellate board at the conclusion of the review indicating the evidence relied upon and justification for the disposition. The statement shall be made available to the resident for review and a copy shall be retained in the resident's file.

§343.286. Room Restriction.

(a) Room restriction may be used in increments of up to 90 minutes for behavior modification.

(b) During room restriction, a juvenile supervision officer shall personally observe and record the resident's behavior at random intervals not to exceed 15 minutes.

§343.288. Disciplinary Seclusion.

(a) Disciplinary seclusion may be used when a resident commits a major rule violation or poses an imminent physical threat to self or others.

(b) A written disciplinary report which describes the resident's precipitating behavior and identifies the staff's response shall be completed promptly, but no later than the end of the shift on which the seclusion occurs. The report shall be submitted immediately to the facility administrator for review.

(c) Seclusion in excess of 24 hours shall be approved in writing by the facility administrator. The written approval of the facility administrator shall also be required for each subsequent 24-hour extension.

(d) The seclusion of a resident with a known diagnosis of a serious mental illness requires consultation with a mental health professional prior to the authorization of any seclusion beyond a 24-hour period. If the seclusion occurs on a holiday or weekend and no mental health professional is available, the facility administrator or designee shall make a referral to the mental health professional and notify the mental health professional of the seclusion. The facility administrator shall consult with the mental health professional as soon as possible after the referral.

(e) During disciplinary seclusion, a juvenile supervision officer shall personally observe and record the resident's behavior at random intervals not to exceed 15 minutes.

(f) In addition to the requirements enumerated in subsections (a) - (c) and (e) of this section, the facility shall provide the secluded resident the disciplinary review mechanisms contained in §343.278 of this chapter.

§343.290. Protective Isolation.

(a) Protective isolation may be ordered when a resident is physically threatened by a resident or a group of residents.

(b) This decision shall be approved in writing by the facility administrator or designee.

(c) While in protective isolation, a juvenile supervision officer shall observe and record the resident's behavior at random intervals not to exceed 15 minutes.

(d) If the protective isolation of a resident exceeds 72 hours, the facility administrator or designee shall immediately conduct a documented review of the circumstances surrounding the level of threat faced by the resident and make a determination as to whether other less restrictive protective measures are appropriate and available. If continued protective isolation is approved, the facility administrator or designee shall ensure that the formalized written review document includes an alternative service delivery plan to ensure the isolated resident is afforded all required program services during their period of protective isolation.

§343.300. Nutritional Requirements.

Meals shall meet the dietary requirements of the United States Department of Agriculture (USDA).

§343.302. Menu Plans.

(a) The facility shall develop and follow daily written menu plans. Menu plans shall be reviewed and approved at least every 365 calendar days by a licensed or provisionally licensed dietician to ensure that the menu plans meet or exceed the requirements of the United States Department of Agriculture (USDA).

(b) If a facility staff determines that there is a legitimate need to deviate from an already approved written menu plan (e.g., delayed food delivery, spoiled/expired food, etc.), the reason for the deviation and menu substitution shall be fully documented. When menu substitutions are made, the substitution shall be of equal portions and nutritional value.

§343.304. Menu Content.

Menus shall contain a variety of foods.

§343.306. Modified Diets.

Modified diets shall be provided upon the recommendation of a health care professional or when a resident's religious beliefs require it.

§343.308. Mealtime Prohibitions.

Residents shall not eat meals in their rooms unless it is necessary for facility safety and security (i.e., assignment to disciplinary seclusion, medical isolation, or assessment isolation or during riot or rebellion).

§343.310. Staff Meals.

Facility staff members on duty where residents are eating are not required to eat, but if they do, they shall eat the same food served to the residents unless a special diet has been ordered by a health care professional or a staff's religious beliefs require it.

§343.312. Daily Meal Schedule.

(a) Three meals shall be provided daily to each resident in the facility.

(b) At least two of the meals shall be hot.

(c) No more than 14 hours may elapse between the evening meal and breakfast unless a snack is provided.

(d) Residents shall be allowed no less than ten minutes to eat once they have received their food.

§343.314. On-site Food Preparation.

A facility that prepares food on site shall maintain a valid permit and any required licenses issued by the local health department or the Texas Department of State Health Services.

§343.316. Off-site Food Preparation.

A facility that receives food from an off-site source shall maintain a copy of the source's valid permit and any required licenses issued by the local health department or the Texas Department of State Health Services. The transfer of such food to the facility shall be conducted in a manner to prevent contamination or adulteration.

§343.320. Health Service Authority.

The facility shall have a designated health service authority responsible for the development and implementation of health care protocols within the facility. The health service authority shall be a physician, physician assistant, registered nurse, nurse practitioner, health administrator, or a medical entity. When a medical entity is designated as the health service authority, an individual shall be identified as the primary point of contact.

§343.322. Health Care Services.

(a) Health Service Plan. The facility shall have a written health service plan developed in consultation with the designated health service authority. The health service plan shall establish the facility's health care delivery system for all residents.

(b) Review of Health Service Plan. The health service plan shall be reviewed at least every 24 months in consultation with the health service authority.

§343.324. Health Services Coordinator.

(a) The facility shall have a designated health services coordinator on staff to coordinate health care delivery in the facility.

(b) If the health services coordinator is not a health care professional, the health services coordinator shall receive special training in health care and health care service delivery topics relevant to detention and correctional facilities and be familiar with local health care providers and facilities.

§343.326. Medical Referral.

If a staff member observes any resident to be in need of medical attention or if a resident requests medical attention, the resident shall be referred for medical services. The resident may not be denied access to health care if the resident will only disclose the condition or reason for the treatment request to a health care professional.

§343.328. Consent for Medical Treatment.

(a) Consent for medical treatment shall be secured in accordance with Chapter 32 of the Texas Family Code.

(b) Documentation of consent for medical treatment received, in accordance with Chapter 32 of the Texas Family Code, shall be maintained in the applicable resident files.

§343.330. Medical Treatment for Victims of Sexual Abuse.

Testing for sexually transmitted diseases, including HIV-AIDS, shall be made available to a resident who, at the conclusion of an internal investigation or Commission investigation of abuse, neglect or exploitation, is found to have been abused, neglected or exploited in a manner by which any physical injuries may have occurred or any sexually transmitted disease may have been contracted. The cost of the testing services and any subsequent medical treatment services shall not be assessed to the resident or the resident's family.

§343.332. Behavioral Health Care Services for Sexual Abuse Victims.

A mental health professional shall assess any resident who, at the conclusion of an internal investigation or Commission investigation of abuse, neglect or exploitation that occurred in the facility, is found to have been the victim of a sexual assault. The mental health professional shall assess the need for crisis intervention counseling and any subsequent long-term, follow-up or counseling services. The cost of the assessment and any subsequent counseling services shall not be assessed to the resident or the resident's family.

§343.334. Confidentiality.

(a) All medical and mental health screenings and assessments shall be conducted in a confidential setting consistent with facility operations and security.

(b) All interactions between a resident and a health care professional that involve treatment or an exchange of confidential medical information shall be conducted in private. The facility's policies and procedures may authorize a juvenile supervision officer to be present in the following situations:

(1) if the resident poses a substantial risk to the safety of the health care professional or others;

(2) if the facility has a written policy requiring the presence of a juvenile supervision officer during medical treatment;

(3) if the health care professional or resident requests the presence of a juvenile supervision officer during the treatment; or

(4) if the circumstances or situation indicate the presence of a juvenile supervision officer is necessary and prudent.

§343.336. Prescription Medication.

(a) Use of Medication. Except upon the order of a physician, physician assistant, dentist or nurse practitioner, no stimulant, tranquilizer, or psychotropic drug shall be administered to residents.

(b) Medication Policy. The juvenile board or governing board of the facility shall adopt a policy concerning the administration of medication to residents. The policy shall specify which facility personnel are authorized to administer medication to residents.

(c) Non-prescription Medication. Only staff that who have had appropriate training in the administration of medication shall administer non-prescription medication (i.e. over-the-counter medication). The medication shall be administered according to the product instructions unless otherwise instructed by the health service coordinator.

§343.338. Medical Isolation.

Medical isolation may be authorized as a health precaution at the direction of a health care professional, facility administrator.

(1) The reasons for the medical isolation of a resident shall be documented and a copy placed in the resident's file.

(2) A resident that has been placed on medical isolation by a facility administrator shall be seen by a health care professional within 12 hours of the initial medical isolation.

(3) During medical isolation, a juvenile supervision officer shall personally observe and record the resident's behavior at random intervals not to exceed 15 minutes.

§343.340. Suicide Prevention Plan.

(a) Plan. The facility shall have a written suicide prevention plan developed in consultation with a mental health professional that, at a minimum, addresses the following components:

(1) definitions of moderate and high risk for suicidal behavior;

(2) a screening methodology to assess and assign a resident's risk of suicide upon admission into the facility, and upon any indication a resident previously screened may now be at moderate or high risk for suicidal behavior. The screening methodology shall include specific provisions regarding the assessment of risk when a resident refuses or is unable to cooperate with the screening process;

(3) communication protocols among facility staff, mental health professionals, the resident's juvenile probation officer, the resident and the resident's parent, legal guardian, or custodian, including communication regarding observations or indications a resident previously screened may now be at moderate or high risk for suicidal behavior;

(4) level of supervision for residents assigned to moderate or high risk for suicidal behavior;

(5) policies and procedures for intervening in suicide attempts;

(6) reporting of resident suicides and attempted suicides, in accordance with any applicable state law, administrative standard, or local policy or ordinance;

(7) staff training on the contents and implementation of the suicide prevention plan;

(8) housing of residents assigned to moderate or high risk for suicidal behavior, including the removal from the resident's presence any dangerous objects which may include clothing and bedding items; and

(9) mortality reviews designed to review the facility's compliance and possible needed revisions to the suicide prevention plan following a resident's suicide.

(b) Implementation. The facility shall implement the suicide prevention plan, and all residents shall be screened and assessed for suicide risk upon admission and as necessary thereafter.

§343.342. Review and Dissemination of Suicide Prevention Plan.

(a) The suicide prevention plan shall be reviewed every 365 calendar days in consultation with a mental health professional.

(b) The suicide prevention plan shall be disseminated or made available to all facility staff having responsibilities named or enumerated in the facility's suicide prevention plan.

§343.346. Mental Health Referral of High Risk Suicidal Youth.

(a) The facility shall refer a resident classified as high risk for suicidal behavior to a mental health professional or mental health agency within 24 hours from the time the resident is classified as such.

(b) The facility shall maintain written documentation that the referral was made. The documentation shall include:

(1) the name and title of the person who notified the mental health professional;

(2) the name and title of the mental health professional or name of the mental health agency notified;

(3) the date and time of the notification;

(4) the method of notification; and

(5) a brief description of the response provided by the mental health professional or a responsive document from the mental health professional.

§343.348. Supervision of High Risk Suicidal Youth.

(a) Observation. During non-program hours, or any time a resident classified as high risk for suicidal behavior is secluded from the general population:

(1) the resident shall be under the continuous, uninterrupted visual supervision of a juvenile supervision officer; and

(2) the supervising juvenile supervision officer shall document his or her personal observations of a high-risk resident at intervals not to exceed 30 minutes.

(b) Required Documentation. The following documentation shall be maintained for high-risk residents:

(1) the date and time the resident was classified as high risk for suicidal behavior;

(2) name and title of the person who classified the resident as high risk for suicidal behavior;

(3) a description of the resident's behavior and/or factors that led up to the resident's classification as high risk for suicidal behavior;

(4) name and title of the juvenile supervision officer providing supervision of the resident;

(5) the location of the resident's supervision;

(6) the date and time the resident was reclassified as no longer being high risk for suicidal behavior; and

(7) the name and title of the mental health professional or physician who recommended the reclassification of the resident as no longer being high risk for suicidal behavior.

(c) Reclassification. Reclassification of a resident designated as high risk for suicidal behavior to a lower risk level shall only be determined by the facility administrator with the recommendation of a qualified mental health professional, a mental health paraprofessional, a mental health professional or a licensed physician.

(1) Prior to recommending reclassification, a qualified mental health professional, mental health paraprofessional, mental health professional or a licensed physician shall conduct a review of the resident's current suicide risk and issue a written recommendation which addresses the following:

(A) the need to re-classify the resident's suicide risk level;

(B) the need for intervention strategies and/or services during the resident's period of confinement within the facility; and

(C) the need for additional assessment(s), screening(s) or evaluation(s).

(2) The written recommendation of the qualified mental health professional, mental health paraprofessional, mental health professional or licensed physician shall be maintained in the resident's record.

(3) The facility administrator or designee shall review the written recommendation of the qualified mental health professional, mental health paraprofessional, mental health professional or licensed physician prior to reclassifying a resident as no longer at high risk for suicidal behavior.

(4) Only the facility administrator or designee shall authorize the reclassification of a resident classified as high risk for suicidal behavior under this subsection.

§343.350. Supervision of Moderate Risk Suicidal Youth.

(a) Observation. Any time a resident is classified as a moderate risk for suicidal behavior and is in individual sleeping quarters, a juvenile supervision officer shall personally observe and record the resident's behavior at random intervals not to exceed ten minutes.

(b) Required Documentation. When providing supervision at random intervals, the juvenile supervision officer shall document:

(1) the date and time the resident was classified as moderate risk for suicidal behavior;

(2) the location of the resident's supervision;

(3) the name and title of the juvenile supervision officer providing supervision of the resident;

(4) each visual observation made and the time of the observation; and

(5) a general description of the resident's behavior.

(c) Reclassification. Only the facility administrator or designee shall authorize the reclassification of a resident classified as moderate risk for suicidal behavior under this section.

§343.352. Visitation.

(a) Residents have the right to receive visitors and to communicate subject only to the limitations authorized in §343.354 of this chapter.

(b) Residents shall be allowed visitation by a parent, legal guardian or custodian at least once every seven calendar days for at least thirty minutes or the equivalent over multiple visits.

(c) The parent, legal guardian or custodian of the resident shall be provided a copy of the visitation schedule.

(d) A registry of all visitors shall be maintained to document the name and relationship to the resident.

§343.354. Limitations on Visitation.

(a) The policies, procedures, and practices of the facility may limit a resident's visitation rights only to the extent required to maintain control and security of the facility.

(b) Restrictions on a resident's visitation rights shall not be imposed as a disciplinary sanction.

(c) The facility administrator or designee shall provide written documentation justifying any restriction placed on a resident's visitation rights.

(d) A resident shall not be denied communication or visitation with a parent, legal guardian, or custodian for a prescribed period of time after admission into the facility.

§343.356. Access to Attorney.

Residents shall be permitted reasonable confidential contact with the resident's attorney and their designated representatives through telephone, uncensored letters, and personal visits.

§343.358. Telephone.

(a) A resident shall be provided the opportunity for at least one five minute phone call every seven calendar days.

(b) Restrictions on a resident's telephone usage shall not be imposed as a disciplinary sanction.

(c) The parent, legal guardian, or custodian of the resident shall be provided a copy of the facility's policy regarding telephone usage.

§343.360. Mail.

(a) Residents shall be provided access to writing materials and postage for no fewer than two letters every seven calendar days.

(b) When a resident is released or transferred from the facility, his or her mail shall be forwarded to the resident's new address.

(c) Money received in the mail shall be held for the resident in their personal property inventory, with receipt provided, or returned to the sender.

§343.362. Limitations on Mail.

(a) Authorized Limitations. A resident's rights to privacy and correspondence may not be limited except when:

(1) a reasonable belief exists to suspect that the correspondence is part of an attempt to formulate, devise, or otherwise effectuate a plan to escape from the facility, or to violate state or federal laws. If such cause exists, then facility staff shall:

(A) ask the resident's permission to read the letter;

(B) if permission is denied, request a search warrant prior to opening and reading the letter; and

(C) if a search warrant request is denied, the correspondence shall be provided to the resident;

(2) correspondence with certain individuals is specifically forbidden by:

(A) the resident's juvenile court-ordered rules of probation or parole;

(B) the facility's rules of separation; or

(C) a specific list of individuals furnished by a resident's parents, legal guardians or custodians indicating who they feel should not communicate with the resident.

(b) Returning Mail. Such incoming correspondence as identified in subsection (a)(2) of this section shall be returned unopened to the sender.

(c) Withholding Mail. When mail is withheld from the resident, the reasons shall be documented and a copy placed in the resident's file.

§343.364. Legal Correspondence.
Residents shall be furnished adequate postage for legal correspondence during their confinement in the facility.

§343.366. Inspection of Mail.
Mail may be opened by staff only in the presence of the resident with inspection limited to searching for contraband.

§343.368. Illegal Discrimination.
Residents shall not be subjected to discrimination based on race, national origin, religion, sex, sexual orientation, gender identity, or disability.

§343.370. Prohibited Supervision.
Residents shall not be subjected to supervision and control by other residents.

§343.372. Work by Residents.

(a) Residents may be required to perform the following types of work responsibilities without monetary compensation:

(1) assignments which are part of a formalized vocational training curriculum;

(2) tasks performed as a community service pursuant to a juvenile court order; and

(3) routine housekeeping chores which are shared by all youth in the facility, including general facility maintenance.

(b) Residents shall not be permitted to perform any work prohibited by state or federal regulations pertaining to child labor.

(c) Repetitive, purposeless, or degrading make-work is prohibited.

(d) A resident's work assignments shall be excused or temporarily suspended if medically contra-indicated.

(e) Residents shall be provided with the necessary supervision, appropriate tools, cleaning implements, and clothing to safely and effectively complete their assignments.

(f) Residents shall not perform personal services for staff.

§343.374. Experimentation and Research Studies.

(a) Experimentation. Participation by residents in medical, psychological, pharmaceutical, or cosmetic experiments is prohibited.

(b) Research Studies. Participation by residents in medical, psychological, pharmaceutical, or cosmetic research is prohibited unless the research study is approved in writing by the juvenile board subject to the following guidelines:

(1) The juvenile board shall promulgate approved policies that govern all authorized research studies. Studies that include medically invasive procedures shall be prohibited.

(2) Approved research studies shall adhere to all applicable policies of the authorizing juvenile board.

(3) Research studies approved by the juvenile board shall be reported to the Commission in a format prescribed by the Commission prior to the commencement of the study.

(4) The results of the study shall be made available to the Commission upon request from the facility administrator, chief administrative officer, or juvenile board.

(5) Policies governing research studies shall adhere to all federal requirements governing human subjects and confidentiality.

§343.376. Resident Grievance Process.
Written policies and procedures, as well as actual practices shall demonstrate that there is a formalized grievance process to address residents' complaints about their treatment and facility services. At a minimum, the formalized grievance process shall include the following policy, procedural, and practice elements:

(1) Residents' ability to submit a grievance with full access to the process;

(2) A written response and resolution to all grievances:

(A) shall be resolved no later than ten calendar days from the date the grievance is received by pre-adjudication staff; or

(B) shall be resolved no later than 30 calendar days from the date the grievance is received by post-adjudication staff;

(3) Confidentiality of grievance without fear of reprisal;

(4) The designation of at least one grievance officer;

(5) At least one level of appeal to an administrative-level staff person or to an administrative-level appeals board or panel;

(6) The resident's ability to participate in the resolution of a grievance, including the use of an intermediary and the ability to request witnesses;

(7) Periodic formal reviews of the grievance process and dispositions by administrative-level staff;

(8) A tracking system and grievance log that accounts for all grievances submitted; and

(9) Unresolved grievances submitted by any resident who is released shall be forwarded to the facility administrator or designee to determine if any action is needed.

§343.378. Grievance Appeals.

(a) The appeal shall be decided in a timely manner after receipt.

(b) The resident shall promptly be notified in writing of the resolution.

§343.380. Grievance Officer.
The duties of a grievance officer shall include:

(1) the maintenance of a current grievance log;

(2) the collection of grievances;

(3) responding to the resident after receiving the grievance;

(4) providing a written resolution to the resident; and

(5) forwarding all appeals to the administrative staff responsible for determining appeals.

§343.382. Grievance Form.
The grievance form shall contain the following elements:

(1) the name of the resident;

(2) the housing unit or cell;

(3) the date of the grievance;

(4) the grievance tracking identification;

(5) the nature or description of the grievance;

(6) the date and time of receipt;

(7) the name and title of the person receiving the grievance;

(8) the response or resolution to the grievance;

(9) the date and time of the response;

(10) the name and title of the person responding to the grievance; and

(11) a space for a written request to appeal the grievance response.

§343.384. Religious Services.

Residents shall not be required to participate in religious services and religious counseling.

§343.386. Volunteers and Interns.

Facilities utilizing a volunteer or internship program shall have written policies and procedures that contain the following components:

(1) a description of the authority, responsibility, and accountability of volunteers and interns who work with the department;

(2) the selection and termination criteria, including disqualification based on specified criminal history;

(3) the orientation and training requirements, including training on recognizing and reporting abuse, neglect, and exploitation;

(4) a requirement that volunteers and interns meet minimum professional requirements if applicable; and

(5) a written volunteer and intern registry, log or other documentation that details all dates and times a volunteer or intern is present on the premises of the facility as well as the purpose of their visit.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER C. SECURE PRE-ADJUDICATION DETENTION FACILITY STANDARDS

37 TAC §§343.400, 343.402, 343.404, 343.406, 343.408, 343.410, 343.412, 343.414, 343.416, 343.418, 343.420, 343.422, 343.424, 343.426, 343.428, 343.430, 343.432, 343.434, 343.436, 343.438, 343.440, 343.442, 343.444, 343.446, 343.448, 343.450, 343.452, 343.454, 343.456, 343.458, 343.460, 343.462, 343.464, 343.468, 343.470, 343.472, 343.474, 343.476, 343.478, 343.480, 343.482, 343.484, 343.486, 343.488 - 343.494, 343.496, 343.498

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new chapter.

§343.400. Intake and Admission.

(a) Intake. An intake officer authorized by the juvenile board shall be on duty at the facility or on-call 24 hours a day.

(b) Pre-Admission Assessment. Each facility shall have written policies and procedures addressing the admission of juveniles who are in need of emergency medical care due to injury, illness, or intoxication or who are in need of emergency mental health services.

(1) Anyone presented for admission into detention and is in need of emergency medical care due to injury, illness, or intoxication, or is in need of mental health intervention, shall not be admitted into detention.

(2) The referring person shall be directed to a health care facility to have the individual evaluated and treated.

(c) Subsequent admission into detention is contingent upon written medical clearance provided by a health care or mental health professional.

(d) Intoxicated or Chemically-Impaired Individuals. Each facility shall have written policies and procedures addressing intoxicated or chemically-impaired juveniles being admitted into detention and their need for specialized supervision.

(e) Intoxicated or chemically-impaired individuals who have been medically cleared for admission should be placed under medical isolation in accordance with §343.338 of this chapter.

(f) A juvenile who has been taken into custody by law enforcement and presented for detention at a secure pre-adjudication detention facility shall:

(1) not be left unsupervised; and

(2) be admitted into detention immediately but no later than six hours from the time of entry.

§343.402. Intake Assessment Period.

(a) Residents shall be assigned to the general program as soon as possible after admittance into the facility.

(b) Assessment isolation for periods of time longer than necessary to assess the risks and needs of a resident is prohibited. Assessment isolation shall not exceed 24 hours.

(c) If a resident is confined in his or her room at admission for assessment purposes, juvenile supervision officers shall document the assessment of the resident during this 24-hour period and retain this documentation in the resident's file.

(d) A juvenile supervision officer shall personally observe and record the behavior of a resident during the assessment period at random intervals not to exceed 15 minutes.

§343.404. Mental Health Screening and Referral.

(a) Mental Health Screening. The standard screening instrument shall be administered to each resident that is admitted into detention within 48 hours.

(b) Positive screening and mental health referral. A resident who scores a positive screening on the standard screening instrument shall be:

(1) administered a secondary screening immediately to assist in clarifying the resident's need for mental health intervention;

(A) If the secondary screening confirms the positive screening and that mental health intervention is warranted, then a referral shall be made to a mental health professional or licensed physician within 48 hours.

(B) If the secondary screening substantiates that the initial positive screening was false, then no further mental health intervention is required; or

(2) referred to a qualified mental health professional or mental health paraprofessional for consultation by the end of the following workday to determine if further intervention is warranted.

(A) The facility shall maintain documentation of the consultation in the resident's file.

(B) If the qualified mental health professional or mental health paraprofessional recommends that further mental health intervention is needed, then the resident must be referred to a mental health professional or a licensed physician within 48 hours.

(c) Documentation of recommendations or referrals specific to the juvenile's positive screening on the standard screening instrument shall be forwarded to the supervising juvenile probation officer if the juvenile is released at any point during the proceedings initiated in subsection (b)(1) and (2) of this section. If the juvenile is released and no further juvenile justice intervention is required, then the documentation shall be forwarded to the juvenile's parent, legal guardian, or custodian.

(d) Documentation of referrals, completed assessments and evaluations, including dates and times, shall be retained in the juvenile's file and forwarded to the supervising juvenile probation officer.

§343.406. Health Screening and Assessment.

(a) Health Screening. A health screening shall be conducted on each resident within two hours of admission by either a health care professional or an individual who has received specific training on administering the facility's health screening. The health screening instrument shall include:

(1) mental health problems;

(2) suicide risk assessment in accordance with the facility's suicide prevention plan;

(3) current state of health including:

(A) allergies;

(B) tuberculosis;

(C) other chronic conditions;

(D) sexually transmitted diseases;

(E) other infectious diseases;

(F) history of gynecological problems or pregnancies; and

(G) recent injuries at or near the time of arrest;

(4) current use of medication including type, dosage, and prescribing physician;

(5) visual observation of teeth and gums and notation of any obvious dental problems;

(6) vision problems;

(7) drug and alcohol use;

(8) physical or developmental disabilities;

(9) evidence of physical trauma;

(10) a determination of the need for medical detoxification from alcohol or other substances or mental health services; and

(11) the resident's weight.

(b) Referral for Assessment. If the health screening indicates that a resident is in need of further medical evaluation, the resident shall be referred to a health care professional for further assessment within 24 hours, excluding holidays and weekends, from the date and time of the completed screening.

(c) Mandatory Health Assessment. If a resident has not had a health assessment by a health care professional within the last 12 months immediately preceding admission into the facility, the resident shall be given a health assessment by a health care professional within 30 calendar days after admission into the facility.

(d) Results of Screening and Assessment. The results of the health screening and health assessment shall be communicated to appropriate staff.

(e) Contagious or Infectious Disease. Any finding of the health screening that indicates a significant potential health risk to the staff or residents from a contagious or infectious disease shall be immediately reported to the facility administrator, and the affected resident shall be placed in medical isolation until proper medical clearance is obtained.

§343.408. Personal Hygiene.

Residents shall be required to surrender their clothing and to shower upon admission into the facility.

§343.410. Personal Property.

A resident's personal property shall be collected, inventoried, and securely stored while the resident is housed in the facility. Documentation that is signed by the resident and the juvenile supervision officer shall be maintained in the resident's file.

§343.412. Orientation.

(a) Each resident shall be provided a verbal orientation within 12 hours of admission into the facility.

(b) The verbal orientation shall include an explanation of the facility's:

(1) procedures to access health care and services available;

(2) program rules with corresponding and maximum disciplinary sanctions;

(3) grievance policies and procedures;

(4) procedures to access mental health care and services available; and

(5) information required by the Prison Rape Elimination Act of 2003 including:

(A) prevention and intervention;

(B) methods of minimizing risk of sexual abuse;

(C) reporting sexual abuse and assault; and

(D) treatment and counseling;

(6) information regarding the reporting of suspected abuse, neglect, or exploitation of a child in a juvenile justice facility; and

(7) policy that states the resident is ensured the right of confidentiality with regard to the items included in paragraphs (3), (5) and (6) of this subsection and will not face reprisal for participating in the procedures included in these items.

(c) If the resident is not sufficiently fluent in English, arrangements shall be made to provide the resident with an orientation in the resident's primary language within 48 hours of admission.

(d) When a literacy problem prevents a resident from understanding written rules, a staff member or translator shall assist the resident within 48 hours of admission.

(e) Each resident shall be provided a written copy of the orientation materials upon completion of the orientation process.

§343.414. Behavioral Screening.

Prior to placing a resident into a housing unit, the resident shall be screened for potential vulnerabilities or tendencies of acting out with sexually aggressive or assaultive behavior. Housing assignments shall be made accordingly.

§343.416. Classification Plan.

All facilities with more than one housing unit shall have a classification plan that takes, at least, the following into account:

(1) age;

(2) sex;

(3) offense;

(4) behavior; and

(5) any other special considerations including a resident's potential vulnerabilities for sexual abuse that are discovered during the resident's behavioral health screening.

§343.418. Admission Records.

The facility shall have the following information which shall be obtained at the time the resident is admitted into the facility:

(1) date and time of entry;

(2) date and time of admission;

(3) name;

(4) nicknames and aliases;

(5) social security number;

(6) current address;

(7) detention criteria as required by §53.02(b) of the Texas Family Code;

(8) referring offense;

(9) name of attorney;

(10) name, title, and signature of delivering individual;

(11) gender;

(12) race;

(13) date of birth;

(14) place of birth;

(15) citizenship;

(16) current education level;

(17) last school attended;

(18) name, relationship, address, and phone number of parents, legal guardians, or custodians; and

(19) primary language of the resident and the resident's parent, legal guardian, or custodian.

§343.420. Format and Maintenance of Records.

(a) Resident records shall be maintained in a uniform format for identifying and separating files.

(b) Each facility shall have written policies and procedures to ensure the confidentiality of resident files.

§343.422. Content of Resident Records.

Each resident's record shall include the following:

(1) the offense narrative, arrest warrant, or directive to apprehend;

(2) the inventory of cash and property surrendered;

(3) the list of approved visitors;

(4) the name of the assigned probation officer;

(5) the behavioral record, including any special incidents, discipline, or grievances;

(6) the referrals to other agencies; and

(7) the final release or transfer report.

§343.424. Housing Records.

For each housing unit in the facility, the following documentation shall be maintained:

(1) a daily chronological log or electronic record documenting the resident's or housing unit's activity that identifies the juvenile supervision officers supervising the residents;

(2) a daily report of admissions and releases; and

(3) a population roster compiled as of 5:00 a.m. each day that shall include at a minimum:

(A) the date and time the roster was compiled;

(B) the name of all residents in the facility;

(C) the sex of all residents in the facility;

(D) the housing assignment location (e.g., the location where the resident sleeps) of all residents in the facility; and

(E) the numerical total of the resident population for each day.

§343.426. Release Procedures.

Prior to the release of a resident from the facility, the authorized officer shall:

(1) verify the identity of the person receiving custody;

(2) verify the release authorization documents;

(3) secure a signed release by the individual receiving the resident's personal property;

(4) provide information to a parent, legal guardian, or custodian regarding:

(A) all medication prescribed while the resident was in the facility that the resident is currently taking, and the name and contact information of the prescribing physician;

(B) any pending medical, mental health, or dental appointments; and

(C) any present concerns regarding the resident; and

(5) secure a receipt signed by the person receiving custody.

§343.428. Resident Supervision.

A juvenile supervision officer may provide resident supervision if they:

(1) are currently certified as a juvenile supervision officer; or

(2) have been employed by the facility less than 180 calendar days;

(A) have passed the competency evaluation exam as detailed in Chapter 344 of this title; and

(B) have completed a minimum of 40 hours of training, which shall include the mandatory topics as outlined in Chapter 344 of this title, as well as certification in CPR, first aid, and a personal restraint technique approved by the Commission.

§343.430. Minimum Facility Supervision.

At least two juvenile supervision officers shall be on duty at any time the facility has a resident. At least one of the officers shall be certified.

§343.432. Gender Supervision Requirement.

(a) If residents of both genders are housed within the facility, juvenile supervision officers of both genders shall be on duty and available to the residents for every shift.

(b) A juvenile supervision officer of one gender shall be prohibited from supervising and visually observing a resident of the opposite gender during showers, physical searches (i.e., strip searches), disrobing of residents (suicidal or not), or when personal hygiene practice (i.e., onset of menstrual cycle, etc.) requires the presence of a juvenile supervision officer of the same gender.

(c) Juvenile supervision officers of one gender shall be the sole supervisors of residents of the same gender during showers, physical searches, pat downs, disrobing of suicidal youth, or during other times in which personal hygiene practices or needs would require the presence of a juvenile supervision officer of the same gender.

§343.434. Facility-Wide Ratio.

The facility-wide juvenile supervision officer-to-resident ratio shall not be less than:

(1) one juvenile supervision officer to every eight residents during program hours; and

(2) one juvenile supervision officer to every 18 residents during non-program hours.

§343.436. Supervision Ratio--SOHU.

In a SOHU, the juvenile supervision officer-to-resident ratio shall not be less than:

(1) one juvenile supervision officer to every 12 residents during program hours; and

(2) one juvenile supervision officer to every 24 residents during non-program hours.

§343.438. Level of Supervision--SOHU.

(a) Program Hours. While residents are located in a SOHU, they shall be in constant physical presence of a juvenile supervision officer unless they are placed in their individual sleeping quarters during shift change, in which case, a juvenile supervision officer shall observe and document each resident's behavior at random intervals not to exceed 15 minutes.

(b) Non-Program Hours. During non-program hours, in a SOHU, a juvenile supervision officer shall visually observe each resident at random intervals not to exceed 15 minutes.

(c) Juvenile supervision officers shall document each visual observation made. The documentation shall include the time of the observation and generally describe the resident's behavior.

§343.440. Supervision Ratio--MOHU.

MOHUs shall maintain a juvenile supervision officer to resident ratio of no less than one juvenile supervision officer to every eight residents in the housing unit.

§343.442. Level of Supervision--MOHU.

(a) For MOHUs designed and operated after June 5, 2001, during program and non-program hours, residents, while physically located in a MOHU, shall be under the constant visual observation of a juvenile supervision officer.

(b) If juvenile supervision officers supervise residents behind an architectural barrier, the barrier shall provide a complete and unobstructed view of the entire multiple occupancy housing unit. The barrier, with or without the assistance of an electronic device, shall allow for constant auditory monitoring of the unit.

(c) Juvenile supervision officers shall document general observations of dorm activity at intervals not to exceed 30 minutes.

§343.444. Supervision On and Off Premises of Facility.

(a) On-Premises Supervision. Subject to §343.436 of this chapter, residents participating in any programming or activities on the facility premises, but outside of a single or multiple occupancy housing unit, shall be in the constant physical presence of a juvenile supervision officer at all times.

(b) Required Ratio. There shall be at least one juvenile supervision officer to every 12 residents participating in the program or activity.

(c) Off-Premises Supervision. A facility shall have written policies and procedures that establish specific resident supervision practices for residents allowed to temporarily leave the secure confines of the facility or the facility's secure grounds. The policies and procedures shall minimally include:

(1) designations of which staff may supervise youth off-premises;

(2) gender-specific requirements;

(3) staff-to-resident ratios when more than one resident is involved;

(4) personnel authorized to use approved restraint practices; and

(5) staff training requirements.

(d) The established policies and procedures shall be written to adequately provide an appropriate level of protection for the public and involved staff and residents.

(e) Exceptions. This standard does not apply to furlough and formal discharge.

(f) If a juvenile probation officer transports a resident off the facility premises, the juvenile probation officer must be currently certified in CPR, First Aid and, if authorized to use, a Commission-approved personal restraint technique.

§343.446. Exceptions to General Levels of Supervision.

A resident shall be in the constant physical presence of a juvenile supervision officer with exception of the following:

(1) Small Groups. No more than three residents may be supervised by a professional when the professional is working with

the residents in a capacity that relates to the professional's licensure, certification, professional training, or education.

(2) Small Therapeutic Groups. A juvenile supervision officer shall provide constant visual supervision of any small group between four and eight residents when those residents are working with a qualified mental health professional, a mental health paraprofessional, or a mental health professional as defined by §343.100(30) of this chapter.

(3) Visitation. Private visitation between one resident and an attorney, authorized visitor, or clergy does not require the constant physical presence of a juvenile supervision officer.

§343.448. Primary Control Room.

A juvenile supervision officer stationed in and assigned to the facility's primary control room(s) shall not count toward meeting any required ratios prescribed by this subchapter.

§343.450. Single Occupancy Housing Units--SOHU.

(a) SOHUs shall be constructed to contain no more than 24 beds in each housing unit.

(b) Individual resident sleeping quarters shall be utilized as single occupancy only; and, at no time, may more than one resident be placed in an individual resident sleeping quarter.

(c) Individual resident sleeping quarters shall contain a bed above floor level.

§343.452. Spatial Requirements--SOHU.

(a) Individual resident sleeping quarters shall have a minimum ceiling height of 7.5 feet.

(b) Individual resident sleeping quarters shall have a minimum of 60 square feet of floor space.

§343.454. Shower Facilities--SOHU.

All SOHUs shall contain at least one operable shower with hot and cold running water for every ten beds in the housing unit.

§343.456. Toilet Facilities--SOHU.

All SOHUs shall contain at least one operable toilet above floor level for every 12 beds in male housing units and one for every eight beds in female housing units.

(1) For facilities constructed after March 1, 1996, the ratio shall be one toilet for every six beds in the housing unit.

(2) Urinals may be substituted for up to one-half of the toilets in housing units permanently designed as all-male units.

§343.458. Washbasin Requirements--SOHU.

All SOHUs constructed and in operation on or after September 1, 2003, shall contain a washbasin with hot and cold running water.

§343.460. Drinking Fountain--SOHU.

All SOHUs shall contain a drinking fountain.

§343.462. Pre-Assignment Screening Process--MOHU.

Residents shall not be admitted into MOHUs directly from the intake process. Classification, screening, and behavioral observation shall occur for at least 72 hours before the decision is made to admit the resident into a MOHU.

§343.464. Administrative Approval--MOHU.

The placement of any resident into a MOHU shall be approved by the facility administrator or designee.

§343.468. Classification Plan--MOHU.

Facilities with multiple occupancy housing units shall have a written classification plan that determines how residents are grouped in housing units. Residents shall, at a minimum, be classified for grouping by age and sex.

§343.470. Eligibility Criteria--MOHU.

(a) A formalized (e.g., written) and objective (e.g., scored and weighted) classification assessment shall be completed prior to a resident being assigned to a MOHU. The classification assessment process shall minimally include a review and weighting of the following criteria:

(1) Physical health--A review of all available health documentation in the facility staffs' possession with an emphasis on assessing any diagnosed or suspected infectious or contagious diseases;

(2) Mental health--A review of all available mental health documentation in the facility staffs' possession with an emphasis on assessing mental health or mental illness diagnoses that could be exacerbated by, or that would not be conducive to, multiple occupancy housing settings;

(3) Sexual behavior--An assessment of the resident's potential to be sexually abused by other residents and his or her potential to be sexually abusive;

(4) Aggressive or assaultive behaviors--An assessment of resident's history of, or propensity for, aggressive (both verbal and physical) and assaultive behaviors. This assessment shall minimally include a review of the resident's formal referral history (both alleged and disposed charges) as well as institutional behavior records;

(5) Susceptibility to acts of peer abuse, harassment, and exploitation--This shall minimally include an assessment of a resident's physical stature, emotional maturity, enemies of record, and social functioning information;

(6) Institutional behavior or discipline records--This assessment shall include a review of a resident's behavior records for the current term of detention as well as any available behavior records from previous institutional custody periods provided by the assessing jurisdiction; and

(7) Special needs or circumstances that may compromise the resident's, or other MOHU residents', physical safety and successful service delivery processes.

(b) The completed classification assessment document shall include an objective assessment score or recommendation for or against a MOHU assignment, the date the assessment process was completed, the signature of the person completing the assessment, and the signature of the supervisory-level staff that reviewed and approved the assessment.

§343.472. Multiple Occupancy Housing Units--MOHU.

(a) The utilization of MOHUs shall have prior written approval and authorization from the governing board of the facility.

(b) Sections 343.462, 343.464, 343.468, 343.470, 343.472, 343.474, 343.476, 343.478, 343.480 and 343.482 of this chapter apply only to MOHUs designed and operating as such on or after June 5, 2001.

(c) MOHUs shall be designed to contain no more than eight beds in each housing unit.

(d) The capacity of MOHUs shall not exceed 25 percent of the design capacity of the facility.

(e) MOHUs shall have one bed above floor level for every resident assigned to the unit.

(f) MOHUs shall contain residents of the same sex.

§343.474. Spatial Requirements--MOHU.

(a) MOHUs shall have a minimum ceiling height of 7.5 feet.

(b) MOHUs shall have a minimum of 35 square feet of unencumbered floor space per bed in the housing unit.

§343.476. Shower Facilities--MOHU.

All MOHUs shall contain at least one operable shower with hot and cold running water for every eight beds in the housing unit.

§343.478. Toilet Facilities--MOHU.

All MOHUs shall contain at least one operable toilet above floor level for every four beds in the housing unit.

§343.480. Washbasin Requirements--MOHU.

All MOHUs shall contain at least one washbasin with hot and cold running water.

§343.482. Drinking Fountain--MOHU.

All MOHUs shall contain a drinking fountain.

§343.484. Exercise and Common Activity Areas.

(a) Exercise Area. The facility shall provide space for an exercise area.

(b) Common Activity Area. The facility's total common activity area shall encompass no less than 100 square feet of floor space per resident.

§343.486. Program Hours.

Each facility shall have a daily written program schedule outlining the stated activities during program hours.

(1) Each resident shall be provided a minimum of ten hours of structured and unstructured activities.

(2) Exceptions. Residents who are in disciplinary seclusion, room restriction, protective isolation, medical isolation, or assessment isolation may receive modification to their respective program schedule.

(3) The facility shall maintain documentation of any program schedule deviation or modification.

§343.488. Educational Program.

(a) The facility administrator shall ensure that there is an educational program that requires all residents to participate. The educational program provided shall be administered in accordance with rules adopted by the Texas Education Agency (TEA).

(b) The facility administrator shall ensure that the education provider has access to residents so that the educational program is afforded to all residents, in accordance with rules adopted by the TEA.

§343.489. Educational Curriculum.

Students shall be provided coursework that is aligned with the Texas Essential Knowledge and Skills, in accordance with rules adopted by the TEA.

§343.490. Instructional Days.

The facility administrator shall ensure that the educational program provides for at least 180 days of instruction unless a waiver has been granted by the TEA for fewer days or the number of educational days coincides with the local school district calendar.

§343.491. Special Education.

(a) The facility administrator, through a cooperative effort with the Local Education Agency (LEA), will ensure that residents with disabilities are provided a free and appropriate public education as determined by the Admission, Review and Dismissal committee in order to meet the individual educational needs of the student as defined by federal and state laws.

(b) The facility administrator, through a cooperative effort with the Local Education Agency (LEA), will ensure that residents with disabilities have available an instructional day commensurate with that of students without disabilities, in accordance with requirements contained in 19 TAC §89.1075(d).

(c) The facility administrator or designee shall send notification of a student placement in a residential facility to the LEA as required by §29.012 of the Texas Education Code and shall retain documentation of this notice.

§343.492. Educational Space.

The facility administrator shall ensure that educational space is adequate to meet the instructional requirements for each resident.

§343.493. Educational Staff Safety.

All permanent educational staff, excluding temporary substitutes, shall receive a facility orientation prior to performing instructional duties. Orientation shall include:

(1) security procedures;

(2) emergency procedures;

(3) behavior management system and prohibited sanctions; and

(4) reporting abuse, neglect and exploitation.

§343.494. Supervision During Educational Program.

Educational staff shall not be counted in staff-to-resident ratios.

§343.496. Reading Materials.

Age-appropriate reading materials shall be available to all residents.

§343.498. Recreation and Exercise.

(a) Supplies. Recreational equipment and supplies shall be provided to the residents.

(b) The recreational schedule shall offer the following programming:

(1) Large Muscle Exercise. At least one hour of large muscle exercise shall be scheduled each day.

(2) Open Recreational Activity. At least one hour of open recreational activity shall be scheduled each day.

(c) Exceptions. A resident's recreational schedule may be altered under the following conditions:

(1) participation by the resident is contra-indicated for medical reasons;

(2) the resident is in disciplinary seclusion, room restriction, protective isolation, medical isolation, or assessment isolation;

(3) the resident has a scheduled appointment;

(4) extenuating circumstances exist that impede the recreational schedule; or

(5) the resident presents an imminent danger to self or others. Utilization of this provision shall require the written approval of the facility administrator.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

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Texas Juvenile Probation Commission
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SUBCHAPTER D. SECURE POST-ADJUDICATION CORRECTIONAL FACILITY STANDARDS

37 TAC §§343.600, 343.602, 343.604, 343.606, 343.608, 343.610, 343.612, 343.614, 343.616, 343.618, 343.620, 343.622, 343.624, 343.626, 343.628, 343.630, 343.632, 343.634, 343.636, 343.638, 343.640, 343.642, 343.644, 343.646, 343.648, 343.650, 343.652, 343.654, 343.656, 343.658, 343.660, 343.662, 343.664, 343.666, 343.668, 343.670 - 343.678, 343.680, 343.686, 343.688, 343.690, 343.700, 343.702, 343.704, 343.706, 343.708, 343.710, 343.712

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new chapter.

§343.600. Required Pre-Admission Records.

Prior to a resident's admission, the facility shall receive the following from the referring agency:

(1) a completed State of Texas Common Application Form, except when the facility is operated by the referring agency;

(2) a psychological evaluation, or behavioral health assessment (as defined in the Compliance Resource Manual), completed within 365 calendar days prior to the resident's admission date;

(3) a signed disposition order or TYC commitment order;

(4) a current immunization record;

(5) a medical examination that was completed within 30 calendar days prior to the resident's admission date;

(6) documentation that a tuberculosis test was administered and results were received no more than 365 calendar days prior to the resident's admission date;

(7) a dental evaluation that was completed within 30 calendar days prior to the resident's admission date;

(8) services needed for the disabled;

(9) primary language of the resident and the resident's parent, legal guardian or custodian; and

(10) school records.

§343.602. Intake and Admission.

(a) Pre-Admission Assessment. Each facility shall have written policies and procedures addressing the admission of juveniles who are in need of emergency medical care due to injury, illness, or intoxication or who are in need of mental health services.

(1) Anyone presented for admission into the facility and is in need of emergency medical care due to injury, illness, or intoxication or is in need of mental health intervention shall not be admitted into the facility.

(2) The referring person shall be directed to a health care facility to have the individual evaluated and treated.

(3) Subsequent admission into the facility is contingent upon written medical clearance provided by a health care or mental health professional.

(b) Intoxicated or Chemically-Impaired Individuals. Each facility shall have written policies and procedures addressing intoxicated or chemically-impaired juveniles being admitted into the facility and their need for specialized supervision.

(c) Intoxicated or chemically-impaired individuals who have been medically cleared for admission should be placed under medical isolation in accordance with §343.338 of this chapter.

§343.604. Health Screening and Assessment.

(a) Health Screening. A health screening shall be conducted on each resident within two hours of admission by either a health care professional or an individual who has received specific training on administering the facility's health screening. The health screening instrument shall include:

(1) mental health problems;

(2) suicide risk in accordance with the facility's suicide prevention plan's screening methodology;

(3) current state of health including:

(A) allergies;

(B) tuberculosis;

(C) other chronic conditions;

(D) sexually transmitted diseases;

(E) other infectious diseases; and

(F) history of gynecological problems or pregnancies;

(4) current use of medication including type, dosage, and prescribing physician;

(5) visual observation of teeth and gums and notation of any obvious dental problems;

(6) vision problems;

(7) drug and alcohol use;

(8) physical and developmental disabilities;

(9) evidence of physical trauma; and

(10) a determination of the need for medical detoxification from alcohol or other substances or mental health intervention.

(b) Referral for Assessment. If the health screening indicates that a resident is in need of further medical evaluation, the resident shall be referred to a health care professional for further assessment within 24 hours, excluding holidays and weekends, from the date and time of the completed screening.

(c) Results of Screening and Assessment. The results of the health screening and health assessment shall be communicated to appropriate staff.

(d) Contagious or Infectious Disease. Any finding of the health screening that indicates a significant potential health risk to the staff or residents from a contagious or infectious disease shall be reported immediately to the facility administrator, and the affected resident shall be placed in medical isolation until proper medical clearance is obtained.

(e) Intra-Jurisdictional Custodial Transfer. For intra-jurisdictional custodial transfer of residents, the only items required for the health screening at admission into a post-adjudication secure correctional facility are items enumerated in subsection (a)(2) and (a)(9) of this section.

§343.606. Orientation.

(a) Each resident shall be provided a verbal orientation within 12 hours of admission into the facility.

(b) The verbal orientation shall include an explanation of the facility's:

(1) procedures to access health care and services available;

(2) program rules with corresponding and maximum disciplinary sanctions;

(3) grievance policies and procedures;

(4) procedures to access mental health care and services available; and

(5) information required by the Prison Rape Elimination Act of 2003 including:

(A) prevention and intervention;

(B) methods for minimizing risk of sexual abuse;

(C) reporting sexual abuse and assault; and

(D) treatment and counseling;

(6) information regarding the reporting of suspected abuse, neglect, or exploitation of a child in a juvenile justice facility; and

(7) information stating that the resident is ensured the right of confidentiality with regard to the items included in paragraphs (3), (5), and (6) of this subsection and will not face reprisal for participating in the procedures included in these items.

(c) If the resident is not sufficiently fluent in English, arrangements shall be made to provide the resident with an orientation in the resident's primary language within 48 hours of admission.

(d) When a literacy problem prevents a resident from understanding written rules, a staff member or translator shall assist the resident within 48 hours.

(e) Each resident shall be provided a written copy of the orientation materials upon completion of the orientation process.

§343.608. Classification Plan.

All facilities with more than one housing unit shall have a classification plan that takes into account at least the following:

(1) age;

(2) sex;

(3) offense;

(4) behavior; and

(5) any other special considerations including a resident's potential vulnerabilities for sexual abuse that are discovered during the resident's behavioral health screening.

§343.610. Classification Plan--Segregation.

The classification plan shall require that residents assigned to progressive sanctions level 5 and below be physically segregated from residents assigned to progressive sanctions levels 6 and 7.

§343.612. Admission Records.

The facility shall obtain and record the following information at the time the resident is admitted into the facility:

(1) date and time of admission;

(2) name;

(3) nicknames and aliases;

(4) social security number;

(5) last known address;

(6) adjudicated offense;

(7) name of attorney;

(8) name, title, and signature of delivering individual;

(9) gender;

(10) race;

(11) date of birth;

(12) citizenship;

(13) place of birth;

(14) name, relationship, address, and phone number of parents, legal guardians, or custodians; and

(15) primary language of resident and resident's parent, legal guardian, or custodian.

§343.614. Format and Maintenance of Records.

(a) Resident records shall be maintained in a uniform format for identifying and separating files.

(b) Each facility shall have written policies and procedures to ensure the confidentiality of resident files.

§343.616. Content of Resident Records.

Each resident's record shall include the following:

(1) delinquent history;

(2) inventory of cash and property surrendered;

(3) list of approved visitors;

(4) name of the assigned probation officer;

(5) behavioral record, including any special incidents, discipline, or grievances;

(6) progress reports; and

(7) final release and transfer report.

§343.618. Housing Records.

For each housing unit in the facility, the following documentation shall be maintained:

(1) a daily chronological log or electronic record documenting the resident's or housing unit's activity that identifies the juvenile supervision officers supervising the residents;

(2) a daily report of admissions and releases; and

(3) a population roster compiled as of 5:00 a.m. each day that shall include, at a minimum:

(A) the date and time the roster was compiled;

(B) the name of all residents in the facility;

(C) the sex of all residents in the facility;

(D) the housing assignment location (i.e., the location where the resident sleeps) of all residents in the facility; and

(E) the numerical total of the resident population for each day.

§343.620. Release Procedures.

Prior to the release of each resident from the facility, the authorized officer shall:

(1) verify the identity of the person receiving custody;

(2) verify the release authorization documents;

(3) secure a signed release by the individual receiving the resident's personal property;

(4) provide information to a parent, legal guardian, or custodian regarding:

(A) all medication prescribed while the resident was in the facility that the resident is currently taking, and the name and contact information of the prescribing physician;

(B) any pending medical, mental health, or dental appointments; and

(C) any present concerns regarding the resident;

(5) secure a receipt signed by person receiving custody.

§343.622. Resident Supervision.

A juvenile supervision officer may provide resident supervision if they:

(1) are currently certified as a juvenile supervision officer; or

(2) have been employed by the facility less than 180 calendar days;

(A) have passed the competency evaluation exam as detailed in Chapter 344 of this title; and

(B) have completed a minimum of 40 hours of training, which shall include the mandatory topics as outlined in Chapter 344 of this title as well as certification in CPR, first aid, and a personal restraint technique approved by the Commission.

§343.624. Minimum Facility Supervision.

At least two juvenile supervision officers shall be on duty at any time the facility has a resident. At least one of the officers shall be certified.

§343.626. Gender Supervision Requirement.

(a) If residents of both genders are housed within the facility, juvenile supervision officers of both genders shall be on duty and available to the residents for every shift.

(b) A juvenile supervision officer of one gender shall be prohibited from supervising and visually observing a resident of the opposite gender during showers, physical searches (i.e., strip searches), disrobing of residents (suicidal or not) or when personal hygiene practice (e.g., onset of menstrual cycle, etc.) requires the presence of a juvenile supervision officer of the same gender.

(c) Juvenile supervision officers of one gender shall be the sole supervisors of residents of the same gender during showers, physical searches, pat downs, disrobing of suicidal youth, or during other times in which personal hygiene practices or needs would require the presence of a juvenile supervision officer of the same gender.

§343.628. Facility-Wide Ratio.

The facility-wide juvenile supervision officer-to-resident ratio shall not be less than:

(1) one juvenile supervision officer to every 8 residents during program hours;

(2) one juvenile supervision officer to every 20 residents during non-program hours; and

(3) one juvenile supervision officer to every 18 residents during non-program hours if a post-adjudication facility is located in the same building as a pre-adjudication facility.

§343.630. Supervision Ratio.

The juvenile supervision officer-to-resident ratio shall not be less than:

(1) one juvenile supervision officer to every 12 residents during program hours;

(2) one juvenile supervision officer to every 24 residents during non-program hours.

§343.632. Level of Supervision--SOHU.

(a) Program Hours. While residents are located in a SOHU, they shall be in constant physical presence of a juvenile supervision officer unless they are placed in their individual sleeping quarters during shift change, in which case, a juvenile supervision officer shall observe and document each resident's behavior at random intervals not to exceed 15 minutes.

(b) Non-Program Hours. During non-program hours, in a SOHU, a juvenile supervision officer shall visually observe each resident at random intervals not to exceed 15 minutes.

(c) Juvenile supervision officers shall document each visual observation made. The documentation shall include the time of the observation and generally describe the resident's behavior.

§343.634. Level of Supervision--MOHU.

(a) While physically located in a MOHU, residents shall be under the constant visual observation of a juvenile supervision officer during program and non-program hours.

(b) Juvenile supervision officers shall document general observations of dorm activity at intervals not to exceed 30 minutes.

§343.636. Supervision On and Off Premises of Facility.

(a) On-Premises Supervision. Subject to §343.628 of this chapter, residents participating in any programming or activities on the facility premises, but outside of a single or multiple occupancy housing unit, shall be in the constant physical presence of a juvenile supervision officer at all times.

(b) Required Ratio. There shall be at least one juvenile supervision officer to every 12 residents participating in the program or activity.

(c) Off-Premises Supervision. A facility shall have written policies and procedures that establish specific resident supervision practices for residents allowed to temporarily leave the secure confines of the facility or the facility's secure grounds. The policies and procedures shall minimally include:

(1) applicable staff designations (i.e., which staff may supervise youth off site);

(2) gender-specific requirements;

(3) staff-to-resident ratios when more than one resident is involved;

(4) personnel authorized to use approved restraint practices; and

(5) staff training requirements.

(d) The established policies and procedures shall be written to adequately provide an appropriate level of protection for the public and involved staff and residents.

(e) Exceptions. This standard does not apply to furlough and formal discharge.

§343.638. Exceptions to General Levels of Supervision.

A resident shall be in the constant physical presence of a juvenile supervision officer with exception of the following:

(1) Small Groups. No more than three residents may be supervised by a professional when the professional is working with the residents in a capacity that relates to the professional's licensure, certification, professional training, or education.

(2) Small Therapeutic Groups. A juvenile supervision officer shall provide constant visual supervision of any small group between four and eight residents when those residents are working with a qualified mental health professional, a mental health paraprofessional, or a mental health professional as defined by §343.100(30) of this chapter.

(3) Visitation. Private visitation between one resident and an attorney, authorized visitor, or clergy does not require the constant physical presence of a juvenile supervision officer.

§343.640. Primary Control Room.

A juvenile supervision officer stationed in and assigned to the facility's primary control room(s) shall not count toward meeting any required ratios prescribed by this subchapter.

§343.642. Single Occupancy Housing Units--SOHU.

(a) SOHUs shall be constructed to contain no more than 24 beds in each housing unit.

(b) Individual resident sleeping quarters shall be utilized as single occupancy only; and at no time, may more than one resident be placed in an individual resident sleeping quarter.

(c) Individual resident sleeping quarters shall contain a bed above floor level.

§343.644. Spatial Requirements--SOHU.

(a) Individual resident sleeping quarters shall have a minimum ceiling height of 7.5 feet.

(b) Individual resident sleeping quarters shall have a minimum of 60 square feet of floor space.

§343.646. Shower Facilities--SOHU.

All SOHUs shall contain at least one operable shower with hot and cold running water for every ten beds in the housing unit.

§343.648. Toilet Facilities--SOHU.

All SOHUs shall contain at least one operable toilet above floor level for every 12 beds in male housing units and one for every eight beds in female housing units.

(1) For facilities constructed after March 1, 1996, the ratio shall be one toilet for every six beds in the housing unit.

(2) Urinals may be substituted for up to one-half of the toilets in housing units permanently designed as all-male units.

§343.650. Washbasin Requirements--SOHU.

All SOHUs constructed and in operation on or after September 1, 2003, shall contain a washbasin with hot and cold running water.

§343.652. Drinking Fountain--SOHU.

All SOHUs shall contain a drinking fountain.

§343.654. Multiple Occupancy Housing Units--MOHU.

(a) MOHUs shall be constructed to contain no more than 24 beds in each housing unit.

(b) MOHUs shall have one bed above floor level for every resident assigned to the unit.

(c) MOHUs shall contain residents of the same sex.

(d) If bunk beds are utilized, they shall not exceed two levels.

§343.656. Spatial Requirements--MOHU.

(a) MOHUs shall have a minimum ceiling height of 7.5 feet.

(b) MOHUs shall have a minimum of 35 square feet of unencumbered floor space per bed in the housing unit.

§343.658. Shower Facilities--MOHU.

All MOHUs shall contain at least one operable shower with hot and cold running water for every ten beds in the housing unit.

§343.660. Toilet Facilities--MOHU.

All MOHUs shall contain at least one operable toilet above floor level for every twelve beds in male housing units and one for every eight beds in female housing units.

(1) For facilities constructed after March 1, 1996, the ratio shall be one toilet for every six beds in the housing unit.

(2) Urinals may be substituted for up to one-half of the toilets in housing units permanently designed as all-male units.

§343.662. Washbasin Requirements--MOHU.

All MOHUs constructed and in operation on or after September 1, 2003, shall contain a washbasin with hot and cold running water.

§343.664. Drinking Fountain--MOHU.

All MOHUs shall contain a drinking fountain.

§343.666. Exercise and Day Room Areas.

(a) Exercise Areas. The facility shall provide an area for indoor and outdoor exercise.

(b) Day Rooms.

(1) Day rooms shall provide a minimum of 35 square feet of space for every resident using the day room at one time, excluding lavatories, showers, and toilets.

(2) Day rooms shall provide sufficient seating and writing surfaces for every resident using the day room at one time.

§343.668. Program Hours.

Each facility shall have a daily written program schedule outlining the stated activities during program hours.

(1) Each resident shall be provided a minimum of ten hours of structured and unstructured activities.

(2) Exceptions. Residents who are in disciplinary seclusion, room restriction, protective isolation, medical isolation, or assessment isolation may receive modification to their respective program schedule.

(3) The facility shall maintain documentation of any program schedule deviation or modification.

§343.670. Educational Program.

(a) The facility administrator shall ensure that there is an educational program that requires all residents to participate. The educational program provided shall be administered in accordance with rules adopted by the Texas Education Agency (TEA).

(b) The facility administrator shall ensure that the education provider has access to residents so that the educational program is afforded to all residents, in accordance with rules adopted by the TEA.

§343.671. Educational Curriculum.

Students shall be provided coursework that is aligned with the Texas Essential Knowledge and Skills, in accordance with rules adopted by the TEA.

§343.672. Instructional Days.

The facility administrator shall ensure that the educational program provides for at least 180 days of instruction unless a waiver has been granted by the TEA for fewer days or the number of educational days coincides with the local school district calendar.

§343.673. Special Education.

(a) The facility administrator, through a cooperative effort with the Local Education Agency (LEA), will ensure that residents with disabilities are provided a free and appropriate public education as determined by the Admission, Review and Dismissal committee in order to meet the individual educational needs of the student as defined by federal and state laws.

(b) The facility administrator, through a cooperative effort with the LEA, will ensure that residents with disabilities have available an instructional day commensurate with that of students without disabilities, in accordance with requirements contained in 19 TAC §89.1075(d).

(c) The facility administrator or designee shall send notification of a student placement in a residential facility to the LEA as required by §29.012 of the Texas Education Code and shall retain documentation of this notice.

§343.674. Educational Space.

The facility administrator shall ensure that educational space is adequate to meet the instructional requirements for each resident.

§343.675. Educational Staff Safety.

All permanent educational staff, excluding temporary substitutes, shall receive a facility orientation prior to performing instructional duties. Orientation shall include:

(1) security procedures;

(2) emergency procedures;

(3) behavior management system and prohibited sanctions; and

(4) reporting abuse, neglect and exploitation.

§343.676. Supervision During Educational Program.

Educational staff shall not be counted in staff-to-resident ratios.

§343.677. Vocational Training Program.

The facility administrator shall ensure that a vocational training program offered to residents, that is not administered by the school and through which no academic credit is gained, is administered by appropriately qualified persons to provide instruction or mentoring in the vocational skills.

§343.678. Reading Materials.

Age-appropriate reading materials shall be available to all residents.

§343.680. Recreation and Exercise.

(a) Supplies. Recreational equipment and supplies shall be provided for use by residents.

(b) The recreational schedule shall offer the following programming:

(1) Large Muscle Exercise. At least one hour of large muscle exercise shall be scheduled each day.

(2) Open Recreational Activity. At least one hour of open recreational activity shall be scheduled each day.

(c) Exceptions. A resident's recreational schedule may be altered under the following conditions:

(1) participation by the resident is contra-indicated for medical reasons;

(2) the resident is in disciplinary seclusion, room restriction, protective isolation, medical isolation, or assessment isolation;

(3) the resident has a scheduled appointment;

(4) extenuating circumstances exist that impede the recreational schedule; or

(5) the resident presents an imminent danger to self or others. Utilization of this provision shall require the written approval of the facility administrator.

§343.686. Rehabilitative Services.

The social services program shall provide for the availability of:

(1) professional counseling services (individual and group);

(2) substance abuse prevention education; and

(3) HIV/AIDS prevention education.

§343.688. Residential Case Plan.

(a) The initial case plan shall be completed no later than 30 calendar days from the resident's date of placement.

(b) The case plan shall contain written documentation acknowledging that the plan was developed in consultation with the resident, the resident's parent, legal guardian, or custodian, and the supervising juvenile probation officer.

(c) The case plan shall contain specific goals for at least the following nine domains:

(1) medical and dental;

(2) safety and security;

(3) recreational;

(4) educational;

(5) mental and behavioral health;

(6) relationship;

(7) socialization;

(8) permanency; and

(9) parent and child participation.

(d) The case plan shall be signed by the resident, the resident's parent, legal guardian, or custodian, the facility's designee and the supervising juvenile probation officer.

(e) The date of the facility designee's signature on the case plan shall be the case plan completion date.

(f) The case plan shall be retained in the resident's case file with written documentation verifying that copies were provided to the resident, the resident's parent, legal guardian, or custodian and the supervising juvenile probation officer.

§343.690. Residential Case Plan Review.

(a) Case plans shall be reviewed 90 calendar days from the date of completion of the initial case plan or case plan review and every 90 calendar days thereafter.

(b) The case plan review shall contain written documentation acknowledging that the review was conducted in consultation with the resident, the resident's parent, legal guardian or custodian, and the supervising juvenile probation officer.

(c) The case plan reviews shall measure the resident's progress toward meeting his/her goals using the six-point scale outlined in Title 1, Part 15, §351.13 of the Texas Administrative Code.

(d) The case plan review shall document any newly identified needs, goals, and interventions for the juvenile and the juvenile's family.

(e) The case plan review shall be signed by the resident, the resident's parent, legal guardian, or custodian, the facility's designee and the supervising juvenile probation officer.

(f) The date of the facility designee's signature on the case plan review shall be the case plan review completion date.

(g) The case plan review shall be retained in the resident's case file with written documentation verifying that copies were provided to the resident, the resident's parent, legal guardian, or custodian, and the supervising juvenile probation officer.

§343.700. Physical Training Program.

Sections 343.700, 343.702, 343.704, 343.706, 343.708, 343.710, and 343.712 of this chapter apply to those facilities that have a physical training program.

§343.702. Governing Board Approval.

Facilities that utilize a physical training program shall have written authorization from the governing board prior to operation.

§343.704. Pre-Admission Requirements.

Prior to admitting a resident into the facility, the following documentation shall be reviewed by the facility administrator or designee:

(1) a medical release signed and dated by a physician approving the resident's participation in the facility's physical training program;

(2) the physician's acknowledgement of the components of the physical training program; and

(3) a psychological evaluation, or behavioral health assessment (as defined in the CRM), which should indicate in writing the appropriateness for the child's placement at the facility based on the needs and/or limitations of the child (i.e., mental illness, history of abuse, etc.).

§343.706. Physical Training Program Plan.

The facility shall have a written physical training program plan developed in consultation with the facility's health service authority and approved by the governing board. The plan shall include:

(1) a physical fitness screening tool that addresses whether the resident has the physical capability to fully participate in the physical training program. The tool shall be selected or developed by the facility administrator or designee;

(2) a curriculum that addresses the specific types of exercises authorized to be used within the program. The curriculum shall:

(A) define the time limitations of the individual exercises used in the physical training program; and

(B) define the set number of repetitions of each exercise per session;

(3) specific minimal criteria to determine when outdoor weather conditions are too extreme or dangerous for physical training. The criteria shall address scheduling changes when necessary to ensure the safety of residents (e.g., seasonal scheduling changes to accommodate for weather patterns);

(4) adjustments for increased dietary allowances in the residents' menu plan to accommodate the need for modified caloric intake and hydration; and

(5) protocols for removal from the program if a resident becomes unfit to participate in the physical training program due to medical or mental health reasons.

§343.708. Injury and Illness.

If a resident is, at any time, deemed unfit to participate in the physical training program due to medical reasons, to return the resident to the program, the facility must obtain a written release signed by a physician indicating that the resident is fit to resume program activities.

§343.710. Disciplinary Sanctions.

The facility shall have written policies and procedures, including guidelines, parameters, and limitations, on the types of physical activity that may be utilized for discipline or refocusing purposes (e.g., physical activities used to discipline for non-compliant behavior or as a substitute for write-ups or disciplinary seclusion).

§343.712. Physical Fitness Screening Tool.

(a) The resident shall not participate in the physical training program until the initial physical fitness screening tool has been completed and evaluated.

(b) Every 30 calendar days, the facility shall administer the physical fitness screening tool to re-evaluate the resident's ability to participate in the physical training program.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902244
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Earliest possible date of adoption: July 19, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER E. RESTRAINTS

37 TAC §§343.800, 343.802, 343.804, 343.806, 343.808, 343.810, 343.812, 343.816, 343.818

These standards are proposed under Texas Human Resources Code §141.042, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules that provide minimum standards for juvenile boards and that are necessary to provide adequate and effective probation services.

No other rule or standard is affected by this new chapter.

§343.800. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless otherwise expressly defined in the chapter:

(1) Approved Personal Restraint Technique--A professionally trained, curriculum-based, and competency-based restraint technique that uses a person's physical exertion to completely or partially constrain another person's body movement without the use of mechanical restraints. Personal restraint techniques shall first be approved for use by the Commission.

(2) Approved Mechanical Restraint Devices--A professionally manufactured and commercially available mechanical device designed to aid in the restriction of a person's bodily movement. Mechanical restraint devices shall first be approved by the Commission. The following are Commission-approved mechanical restraint devices:

(A) Ankle Cuffs--A metal band designed to be fastened around the ankle to restrain free movement of the legs;

(B) Handcuffs--Metal devices designed to be fastened around the wrist to restrain free movement of the hands and arms;

(C) Plastic Cuffs--Plastic devices designed to be fastened around the wrists or legs to restrain free movement of hands, arms or legs;

(D) Restraint Bed--A professionally manufactured and commercially available bed, or integrated bed attachment(s), specifically designed to facilitate safe human restraint applications.

(E) Restraint Chair--A professionally manufactured and commercially available restraint apparatus specifically designed for safe human restraint. The device's design facilitates the almost complete immobilization of a subject in an upright sitting position by restricting the subject's extremities, upper leg area, and torso through the application of soft-restraints. The apparatus may be fixed or wheeled for re-location;

(F) Waist Belt--A cloth, leather, or metal band designed to be fastened around the waist used to secure the arms to the sides or front of the body; and

(G) Wristlets--A cloth or leather band designed to be fastened around the wrist, which may be secured to a waist belt or used in a non-ambulatory mechanical restraint.

(3) Chemical Restraint--The application of a chemical agent on a resident or residents.

(4) Four-Point Restraint--The use of approved mechanical restraint devices applied to each of a resident's wrists and ankles to secure a resident in a supine position to a restraint bed.

(5) Mechanical Restraint--The application of an approved mechanical restraint device which restricts or aids in the restriction of the movement of the whole or a portion of an individual's body to control physical activity.

(6) Non-Ambulatory Mechanical Restraint--A method of prohibiting a resident's ability to stand upright and walk with the use of a combination of approved mechanical restraint devices, cuffing techniques and the subject's body positioning. The four-point restraint and a restraint chair are examples of acceptable non-ambulatory mechanical restraints.

(7) Personal Restraint--The application of physical force alone, restricting the free movement of the whole or a portion of an individual's body to control physical activity.

(8) Physical Escort--Touching or holding a resident with a minimum use of force for the purpose of directing the resident's movement from one place to another. A physical escort is not considered a personal restraint.

(9) Protective Devices--Professionally manufactured devices used for the protection of residents or staff that do not restrict the movement of a resident. Protective devices are not considered mechanical restraint devices.

(10) Restraint--The application of an approved personal restraint technique, an approved mechanical restraint device, or a chemical restraint to an individual so as to restrict the individual's freedom of movement or to modify the individual's behavior.

(11) Riot--A situation in which three or more persons in the facility intentionally participate in conduct that constitutes a clear and present danger to persons or property and substantially obstructs the performance of facility operations or a program therein. Rebellion is a form of riot.

(12) Soft Restraints--Non-metallic wristlets and anklets used as stand-alone restraint devices or in conjunction with a restraint bed or restraint chair. These devices are designed to reduce the incidence of skin, nerve, and muscle, damage to the restrained subject's extremities.

§343.802. Requirements.

(a) Restraints shall only be used by juvenile supervision and probation officers.

(b) Prior to participating in any restraint, juvenile probation officers and juvenile supervision officers shall be trained in the use of the facility's specific verbal de-escalation policies, procedures, and practices.

(c) Prior to participating in a restraint, juvenile probation officers and juvenile supervision officers shall have received training and demonstrated competency in the Commission-approved restraint used by the facility.

(d) Restraints shall only be used in instances of an imminent threat of self injury, injury to others or serious property damage, or to prevent escapes.

(e) Restraints shall only be used as a last resort.

(f) Only the amount of force and type of restraint necessary to control the situation shall be used.

(g) Restraints shall be implemented in such a way as to protect the health and safety of the resident and others.

(h) Restraints shall be terminated as soon as the resident's behavior indicates that the imminent threat of self injury, injury to others, serious property damage, or the threat of escape has subsided.

§343.804. Prohibitions.

Restraints that employ a technique listed below are prohibited:

(1) restraints used for punishment, discipline, retaliation, harassment, compliance, intimidation, or as a substitute for an appropriate disciplinary seclusion;

(2) restraints that deprive the resident of basic human necessities, including restroom privileges, water, food, and clothing;

(3) restraints that are intended to inflict pain;

(4) restraints that place a resident in a prone or supine position with sustained or excessive pressure on the back, chest, or torso;

(5) restraints that place a resident in a prone or supine position with pressure on the neck or head;

(6) restraints that obstruct the resident's airway, including a procedure that places anything in, on, or over the resident's mouth or nose;

(7) restraints that interfere with the resident's ability to communicate;

(8) restraints that obstruct the view of the resident's face;

(9) any technique that does not require the monitoring of the resident's respiration and other signs of physical distress during the restraint; and

(10) percussive or electrical shocking devices.

§343.806. Documentation.

Except for §343.818 of this chapter, all restraints shall be fully documented and maintained. Written documentation regarding the use of restraints shall, at a minimum, require:

(1) the name of the resident;

(2) the staff member(s) name and title(s) who administered the restraint;

(3) the date of the restraint;

(4) the duration of each type of restraint, including notation of the time each type of restraint began and ended;

(5) the location of the restraint;

(6) the description of the preceding activities;

(7) the behavior which prompted the initial and the continued restraint of the resident;

(8) the type of restraint(s) applied;

(A) the specific type of personal restraint hold applied;

(B) the type of mechanical restraint device(s) applied; and

(C) the type of chemical restraint(s) utilized;

(9) de-escalation efforts as well as all restraint alternatives attempted; and

(10) whether or not any injury occurred during the restraint and the description of the injury.

§343.808. Personal Restraint.

In addition to the requirements found in §§343.802, 343.804, and 343.806 of this chapter, the use of personal restraints shall be governed by the following criteria:

(1) Personal restraints shall be administered in a manner specific, or consistent, to the approved personal restraint technique adopted by the facility.

(2) Juvenile supervision and probation officers shall be retrained in the approved personal restraint technique at least every 365 calendar days.

§343.810. Mechanical Restraint.

(a) Requirements.

(1) Only the approved mechanical restraint devices shall be used by a facility.

(2) Mechanical restraint devices shall only be used in a manner consistent with their intended use.

(3) All mechanical restraint devices shall be inspected at least every 365 calendar days, with all faulty or malfunctioning devices restricted from use until they are repaired or replaced.

(b) Prohibitions.

(1) Approved mechanical restraint devices shall not be altered from the manufacturer's design.

(2) A resident shall not be placed in a prone position while restrained in any mechanical restraint for a period of time longer than necessary to apply the restraint device.

(3) A mechanical restraint shall not secure a resident in a prone, supine, or lateral position with his or her arms and hands behind the resident's back and secured to the resident's legs.

(4) Approved mechanical restraint devices shall not be secured so tightly as to interfere with circulation or so loosely as to cause chafing of the skin.

(5) Approved mechanical restraint devices shall not be secured to a stationary object, except when complete immobilization is required by use of a four-point restraint or a restraint chair.

(6) A resident in an approved mechanical restraint device shall not participate in any physical activity.

(7) Plastic cuffs shall only be used in emergency situations.

§343.812. Non-Ambulatory Mechanical Restraints.

(a) Non-ambulatory mechanical restraints shall only be used in response to a resident's overt behavior specific to self injury and only when other less restrictive interventions, or other forms of physical restraint, have been deemed to be inappropriate or ineffective.

(b) The initial use of non-ambulatory mechanical restraints shall receive incident-specific authorization from the facility administrator or designee. Standing orders authorizing non-ambulatory mechanical restraints are prohibited.

(c) Non-ambulatory mechanical restraints shall be conducted in an area or room which is not visible to other residents but in a location that is readily accessible to health care professionals or specially-trained staff with supervisory responsibilities specific to the oversight of the non-ambulatory mechanical restraints.

(d) Rooms or cells with fixed or static non-ambulatory mechanical restraint fixtures, mechanisms, etc. (e.g. anchoring points or devices), shall not be used to house residents not being restrained in a non-ambulatory mechanical restraint unless they are being provided constant supervision.

(e) Non-ambulatory mechanical restraints shall be restricted to only standards-compliant restraint beds, restraint chairs and soft restraint devices.

(f) A written recommendation from a health care professional or a mental health professional is required in order for a non-ambulatory mechanical restraint to continue longer than one hour.

(g) Non-ambulatory mechanical restraints lasting two hours in duration shall be considered a behavioral health crisis and shall result in an immediate referral to a mental health professional or a mental health facility for assessment and possible treatment.

(h) Under no circumstances shall a non-ambulatory mechanical restraint exceed three hours in duration within a 24 hour period.

(i) Residents in a non-ambulatory mechanical restraint shall be provided:

(1) constant visual supervision by a juvenile supervision officer;

(2) an opportunity for expanded physical motion or movement of not less than five minutes at every 30 minute interval;

(3) an opportunity to drink water every hour;

(4) regularly prescribed medications, unless otherwise ordered by a physician; and

(5) bathroom privileges offered at least every hour.

(j) Requirements enumerated in subsection (i)(1) - (5) of this section shall be fully documented and retained in the facility record or resident file.

(k) The following documentation shall be retained in the facility record or resident file:

(1) an assessment of the resident's circulation, positioning, and breathing conducted at least every ten minutes by a specially-trained juvenile supervision officer or a health care professional; and

(2) documented checks, performed by a health care professional, or specially-trained staff, of the physical condition of the resident and the placement of the mechanical restraint devices within the first 30 minutes of the restraint and every hour thereafter.

(l) The officer responsible for providing the constant visual supervision of a resident in a non-ambulatory mechanical restraint shall have physical possession of the key or other mechanism for releasing the resident from the restraint.

(m) Any juvenile probation officer or juvenile supervision officer authorized to place a resident in a non-ambulatory mechanical restraint, shall be trained in topics that include, but are not limited to:

(1) monitoring the vital signs and critical circulation points of a resident placed in the non-ambulatory mechanical restraint; and

(2) emergency procedures for the removal of a resident from the non-ambulatory mechanical restraint.

§343.816. Chemical Restraints.

In addition to the requirements found in §§343.802, 343.804, and 343.806 of this chapter, the use of chemical restraints shall be governed by the following criteria:

(1) chemical restraints shall only be used in response to episodes of resident riot and only then when other forms of approved restraints are deemed to be inappropriate or ineffective;

(2) the use of chemical restraints shall receive incident-specific authorization from the facility administrator. Standing orders authorizing chemical restraints are prohibited;

(3) chemical restraints are restricted to professionally manufactured and commercially available defense sprays and vaporizing agents containing either Oleoresin Capsicum (i.e., OC pepper sprays) or Orthochlorobenzalmalonoitrile (i.e., tear gas);

(4) chemical restraint deployment devices shall be stored in a locked area, and the issuance of these devices to juvenile supervision officers shall not commence until the facility administrator's authorization has been provided;

(5) chemical restraints shall not be used on a resident when he or she is in a personal or mechanical restraint, or otherwise under control;

(6) immediately following the use of a chemical restraint, the exposed resident shall be visually or physically examined by a medical professional and provided treatment if necessary; and

(7) chemical agent compatible neutralizers or decontaminants shall be readily available for use on residents who have been exposed to chemical restraints.

§343.818. Preventative Mechanical Restraints.

For resident, staff, and public safety purposes, a resident may be placed in ankle cuffs, handcuffs, wristlets or a waist belt absent the imminent threat requirements enumerated in §343.802(d) of this chapter. These types of preventative mechanical restraints are authorized under the following circumstances:

(1) Intra-facility relocation. Mechanical restraints may be used when moving a resident from point to point within a secure facility. The mechanical restraint devices shall be removed upon completion of the resident's relocation.

(2) Vehicular transport. A resident shall not be secured to:

(A) any part of the vehicle; or

(B) another resident.

(3) Off-site activities. Mechanical restraints may be used when a resident is required to leave the secure confines of the facility.

(4) The routine, preventative mechanical restraint applications used in this section are exempt from the documentation requirements contained in §343.806 of this chapter, except when the resident's cooperation is compelled through the use of a personal or chemical restraint; when the resident receives an injury in relation to the restraint event or restraint devices; or when the resident's behavior escalates to the imminent threat criteria listed in §343.802(d) of this chapter.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902245
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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CHAPTER 348. JUVENILE JUSTICE ALTERNATIVE EDUCATION PROGRAMS
SUBCHAPTER A. PROGRAM OPERATIONS

37 TAC §348.16, §348.17

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office,

Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The Texas Juvenile Probation Commission (TJPC) proposes the repeal of §348.16 and §348.17 relating to program operations. The repeal is in an effort not to overlap with newly adopted standards in Chapters 350 and 358 related to abuse, neglect and exploitation investigations.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the repeal is in effect, there will be no fiscal implications for state government or small businesses as a result of enforcement or implementation.

Ms. Capers has also determined that for each year of the first five years the repeal is in effect, the public benefit expected as a result of the repeal will provide TJPC with a more accurate account in evaluating the effectiveness and services provided within the juvenile probation system. There will be no impact on small business or individuals as a result of the repeal.

Public comments on the proposed repeal may be submitted in writing to Diane Laffoon at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547. Comments may also be submitted electronically to *Diane.Laffoon@tjpc.state.tx.us* or faxed to (512) 424-6718.

This repeal is proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§348.16. Serious Incidents.

§348.17. Abuse, Exploitation and Neglect.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902257
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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CHAPTER 349. GENERAL ADMINISTRATIVE STANDARDS
SUBCHAPTER F. ABUSE, EXPLOITATION AND NEGLECT INVESTIGATIONS

37 TAC §§349.42 - 349.51

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The Texas Juvenile Probation Commission (TJPC) proposes the repeal of §§349.42 - 349.51 relating to abuse, exploitation and neglect investigations. The repeal is in an effort not to overlap with newly adopted standards in Chapters 350 and 358 related to abuse, neglect and exploitation investigations.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the repeal is in effect, there will be no fiscal implications for state government or small businesses as a result of enforcement or implementation.

Ms. Capers has also determined that for each year of the first five years the repeal is in effect, the public benefit expected as a result of the repeal will provide TJPC with a more accurate account in evaluating the effectiveness and services provided within the juvenile probation system. There will be no impact on small business or individuals as a result of the repeal.

Public comments on the proposed repeal may be submitted in writing to Diane Laffoon at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547. Comments may also be submitted electronically to *Diane.Laffoon@tjpc.state.tx.us* or faxed to (512) 424-6718.

This repeal is proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§349.42. Applicability.
§349.43. Definitions.
§349.44. Serious Incident Reports.
§349.45. Notification to Law Enforcement.
§349.46. Priorities for Investigation.
§349.47. Roles Assigned at Assessment.
§349.48. Investigation Steps.
§349.49. Investigation Process, Disposition and Roles.
§349.50. Notification of Disposition.
§349.51. Notice of TJPC Standards Non-Compliance and Risk Assessment.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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CHAPTER 351. STANDARDS FOR SHORT-TERM DETENTION FACILITIES
SUBCHAPTER B. SHORT-TERM DETENTION FACILITY STANDARDS

37 TAC §351.3

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the

Texas Juvenile Probation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The Texas Juvenile Probation Commission (TJPC) proposes the repeal of §351.3 relating to short-term detention facility standards. The repeal is in an effort not to overlap with newly adopted standards in Chapters 350 and 358 related to abuse, neglect and exploitation investigations.

Lisa Capers, Deputy Executive Director and General Counsel, has determined that for the first five year period the repeal is in effect, there will be no fiscal implications for state government or small businesses as a result of enforcement or implementation.

Ms. Capers has also determined that for each year of the first five years the repeal is in effect, the public benefit expected as a result of the repeal will provide TJPC with a more accurate account in evaluating the effectiveness and services provided within the juvenile probation system. There will be no impact on small business or individuals as a result of the repeal.

Public comments on the proposed repeal may be submitted in writing to Diane Laffoon at the Texas Juvenile Probation Commission, P.O. Box 13547, Austin, Texas 78711-3547. Comments may also be submitted electronically to *Diane.Laffoon@tjpc.state.tx.us* or faxed to (512) 424-6718.

This repeal is proposed under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with the authority to adopt reasonable rules which provide minimum standards for juvenile boards.

No other code or article is affected by this repeal.

§351.3. Treatment and Safety.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Lisa A. Capers
Deputy Executive Director and General Counsel
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WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

TITLE 22. EXAMINING BOARDS

PART 9. TEXAS MEDICAL BOARD

CHAPTER 174. TELEMEDICINE

22 TAC §§174.1, 174.2, 174.4, 174.6

The Texas Medical Board withdraws the proposed amendments to §§174.1, 174.2, 174.4, and 174.6 which appeared in the May 1, 2009, issue of the *Texas Register* (34 TexReg 2671).

Filed with the Office of the Secretary of State on June 4, 2009.

TRD-200902223
Mari Robinson, J.D.
Interim Executive Director
Texas Medical Board
Effective date: June 4, 2009
For further information, please call: (512) 305-7016

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CHAPTER 190. DISCIPLINARY GUIDELINES
SUBCHAPTER B. VIOLATION GUIDELINES

22 TAC §190.8

The Texas Medical Board withdraws the emergency adoption of the amendment to §190.8, which appeared in the March 27, 2009, issue of the *Texas Register* (34 TexReg 2067).

Filed with the Office of the Secretary of State on June 4, 2009.

TRD-200902224
Mari Robinson, J.D.
Interim Executive Director
Texas Medical Board
Effective date: June 24, 2009
For further information, please call: (512) 305-7016

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 11. TEXAS JUVENILE PROBATION COMMISSION

CHAPTER 343. STANDARDS FOR SECURE JUVENILE PRE-ADJUDICATION DETENTION AND POST-ADJUDICATION CORRECTIONAL FACILITIES

SUBCHAPTER A. DEFINITIONS

37 TAC §343.1

The Texas Juvenile Probation Commission withdraws the proposed repeal of §343.1 which appeared in the January 30, 2009, issue of the *Texas Register* (34 TexReg 525).

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902260
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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SUBCHAPTER B. PRE-ADJUDICATION AND POST-ADJUDICATION SECURE FACILITY STANDARDS

37 TAC §§343.2 - 343.17

The Texas Juvenile Probation Commission withdraws the proposed repeal of §§343.2 - 343.17 which appeared in the January 30, 2009, issue of the *Texas Register* (34 TexReg 525).

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Lisa A. Capers
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SUBCHAPTER C. PRE-ADJUDICATION SECURE DETENTION FACILITY STANDARDS

37 TAC §§343.30 - 343.37

The Texas Juvenile Probation Commission withdraws the proposed repeal of §§343.30 - 343.37 which appeared in the January 30, 2009, issue of the *Texas Register* (34 TexReg 525).

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Lisa A. Capers
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Texas Juvenile Probation Commission
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SUBCHAPTER D. POST-ADJUDICATION SECURE CORRECTIONAL FACILITY STANDARDS

37 TAC §§343.45 - 343.52

The Texas Juvenile Probation Commission withdraws the proposed repeal of §§343.45 - 343.52 which appeared in the January 30, 2009, issue of the *Texas Register* (34 TexReg 525).

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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SUBCHAPTER E. RESTRAINTS

37 TAC §§343.60 - 343.68

The Texas Juvenile Probation Commission withdraws the proposed repeal of §§343.60 - 343.68 which appeared in the January 30, 2009, issue of the *Texas Register* (34 TexReg 525).

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Lisa A. Capers
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Effective date: June 5, 2009
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CHAPTER 343. SECURE JUVENILE PRE-ADJUDICATION DETENTION AND POST-ADJUDICATION CORRECTIONAL FACILITIES

SUBCHAPTER A. DEFINITIONS AND APPLICABILITY

37 TAC §§343.100, 343.102, 343.104, 343.106

The Texas Juvenile Probation Commission withdraws the proposed new §§343.100, 343.102, 343.104, and 343.106 which appeared in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2451).

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SUBCHAPTER B. PRE-ADJUDICATION AND POST-ADJUDICATION SECURE FACILITY STANDARDS

37 TAC §§343.200, 343.202, 343.204, 343.206, 343.208, 343.210, 343.212, 343.214, 343.218, 343.220, 343.222, 343.224, 343.226, 343.228, 343.230, 343.232, 343.234, 343.236, 343.238, 343.240, 343.242, 343.244, 343.246, 343.248 - 343.250, 343.260, 343.262, 343.264, 343.266, 343.268, 343.270, 343.272, 343.274, 343.276, 343.278, 343.280, 343.282, 343.286, 343.288, 343.290, 343.300, 343.302, 343.304, 343.306, 343.308, 343.310, 343.312, 343.314, 343.316, 343.320, 343.322, 343.324, 343.326, 343.328, 343.330, 343.332, 343.334, 343.336, 343.338, 343.340, 343.342, 343.346, 343.348, 343.350, 343.352, 343.354, 343.356, 343.358, 343.360, 343.362, 343.364, 343.366, 343.368, 343.370, 343.372, 343.374, 343.376, 343.378, 343.380, 343.382, 343.384, 343.386

The Texas Juvenile Probation Commission withdraws the proposed new §§343.200, 343.202, 343.204, 343.206, 343.208, 343.210, 343.212, 343.214, 343.218, 343.220, 343.222, 343.224, 343.226, 343.228, 343.230, 343.232, 343.234, 343.236, 343.238, 343.240, 343.242, 343.244, 343.246, 343.248 - 343.250, 343.260, 343.262, 343.264, 343.266, 343.268, 343.270, 343.272, 343.274, 343.276, 343.278, 343.280, 343.282, 343.286, 343.288, 343.290, 343.300, 343.302, 343.304, 343.306, 343.308, 343.310, 343.312, 343.314, 343.316, 343.320, 343.322, 343.324, 343.326, 343.328, 343.330, 343.332, 343.334, 343.336, 343.338, 343.340, 343.342, 343.346, 343.348, 343.350, 343.352, 343.354, 343.356, 343.358, 343.360, 343.362, 343.364, 343.366, 343.368, 343.370, 343.372, 343.374, 343.376, 343.378, 343.380, 343.382, 343.384, and 343.386 which appeared in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2451).

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Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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SUBCHAPTER C. SECURE PRE-ADJUDICATION DETENTION FACILITY STANDARDS

37 TAC §§343.400, 343.402, 343.404, 343.406, 343.408, 343.410, 343.412, 343.414, 343.416, 343.418, 343.420, 343.422, 343.424, 343.426, 343.428, 343.430, 343.432,

343.434, 343.436, 343.438, 343.440, 343.442, 343.444, 343.446, 343.448, 343.450, 343.452, 343.454, 343.456, 343.458, 343.460, 343.462, 343.464, 343.468, 343.470, 343.472, 343.474, 343.476, 343.478, 343.480, 343.482, 343.484, 343.486, 343.488 - 343.494, 343.496, 343.498

The Texas Juvenile Probation Commission withdraws the proposed new §§343.400, 343.402, 343.404, 343.406, 343.408, 343.410, 343.412, 343.414, 343.416, 343.418, 343.420, 343.422, 343.424, 343.426, 343.428, 343.430, 343.432, 343.434, 343.436, 343.438, 343.440, 343.442, 343.444, 343.446, 343.448, 343.450, 343.452, 343.454, 343.456, 343.458, 343.460, 343.462, 343.464, 343.468, 343.470, 343.472, 343.474, 343.476, 343.478, 343.480, 343.482, 343.484, 343.486, 343.488 - 343.494, 343.496, and 343.498 which appeared in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2451).

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: June 5, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER D. SECURE POST-ADJUDICATION CORRECTIONAL FACILITY STANDARDS

37 TAC §§343.600, 343.602, 343.604, 343.606, 343.608, 343.610, 343.612, 343.614, 343.616, 343.618, 343.620, 343.622, 343.624, 343.626, 343.628, 343.630, 343.632, 343.634, 343.636, 343.638, 343.640, 343.642, 343.644, 343.646, 343.648, 343.650, 343.652, 343.654, 343.656, 343.658, 343.660, 343.662, 343.664, 343.666, 343.668, 343.670 - 343.678, 343.680, 343.686, 343.688, 343.690, 343.700, 343.702, 343.704, 343.706, 343.708, 343.710, 343.712

The Texas Juvenile Probation Commission withdraws the proposed new §§343.600, 343.602, 343.604, 343.606, 343.608, 343.610, 343.612, 343.614, 343.616, 343.618, 343.620, 343.622, 343.624, 343.626, 343.628, 343.630, 343.632, 343.634, 343.636, 343.638, 343.640, 343.642, 343.644, 343.646, 343.648, 343.650, 343.652, 343.654, 343.656, 343.658, 343.660, 343.662, 343.664, 343.666, 343.668, 343.670 - 343.678, 343.680, 343.686, 343.688, 343.690, 343.700, 343.702, 343.704, 343.706, 343.708, 343.710, and 343.712 which appeared in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2451).

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SUBCHAPTER E. RESTRAINTS

37 TAC §§343.800, 343.802, 343.804, 343.806, 343.808, 343.810, 343.812, 343.816, 343.818

The Texas Juvenile Probation Commission withdraws the proposed new §§343.800, 343.802, 343.804, 343.806, 343.808, 343.810, 343.812, 343.816, and 343.818 which appeared in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2451).

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Lisa A. Capers
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ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 100. CHARTERS

SUBCHAPTER AA. COMMISSIONER'S RULES CONCERNING OPEN-ENROLLMENT CHARTER SCHOOLS

The Texas Education Agency (TEA) adopts amendments to §§100.1011, 100.1022, 100.1023, 100.1031, 100.1047, and 100.1155, concerning open-enrollment charter schools. The amendments are adopted without changes to the proposed text as published in the December 5, 2008, issue of the *Texas Register* (33 TexReg 9849) and will not be republished. The sections address general provisions as well as provisions relating to commissioner action and intervention, funding and financial operations, and governance. The adopted rule actions modify a definition, update statutory citations and *Texas Administrative Code* references, and remove a provision relating to a repealed rule.

In accordance with House Bill 6, 77th Texas Legislature, 2001, the commissioner exercised rulemaking authority to adopt 19 TAC Chapter 100, Charters, Subchapter AA, Commissioner's Rules Concerning Open-Enrollment Charter Schools, covering a wide range of issues related to open-enrollment charter schools. The rules in 19 TAC Chapter 100, Subchapter AA, are organized in divisions addressing related subject matter, as follows: Division 1, General Provisions; Division 2, Commissioner Action and Intervention; Division 3, Charter School Funding and Financial Operations; Division 4, Property of Open-Enrollment Charter Schools; Division 5, Charter School Governance; and Division 6, Charter School Operations. During the recent required review of rules in 19 TAC Chapter 100, Subchapter AA, staff identified the need to modify a definition, update statutory citations and *Texas Administrative Code* references, and remove reference to a repealed rule. The adopted amendments affect rules in Divisions 1, 2, 3, and 5, as follows.

Division 1. General Provisions.

The adopted amendment to 19 TAC §100.1011, Definitions, modifies the definition of "former charter holder" by including those charter schools that have been ordered closed by any applicable section of the Texas Education Code (TEC), Chapter 39, Public School System Accountability.

Division 2. Commissioner Action and Intervention.

The adopted amendment to 19 TAC §100.1022, Standards for Adverse Action on an Open-Enrollment Charter, updates all references to TEC, §7.027(a), with the correct statutory reference of TEC, §7.028, regarding compliance monitoring. In addition, subsection (c) was modified to reflect the correct title of 19 TAC Chapter 97, Subchapter DD, and subsection (g)(4)(C)(vi) was updated to reflect the correct title of 19 TAC §100.1027.

The adopted amendment to 19 TAC §100.1023, Intervention Based on Charter Violations, corrects the title of 19 TAC Chapter 97, Subchapter DD, in subsection (b).

The adopted amendment to 19 TAC §100.1031, Charter Renewal, updates the reference in subsection (c) to TEC, §12.112, with the correct statutory reference of TEC, §12.114(a), regarding the revision of a charter contract.

Division 3. Charter School Funding and Financial Operations.

The adopted amendment to 19 TAC §100.1047, Accounting for State Funds, revises subsection (d) to delete a provision relating to repealed 19 TAC §129.22, Court-Related Students, and reorganize the existing provision for reporting actual student attendance data to the TEA.

Division 5. Charter School Governance.

The adopted amendment to 19 TAC §100.1155, Procedures for Prohibiting a Management Contract, updates subsection (b) to reflect the correct title of 19 TAC Chapter 97, Subchapter DD, and subsection (b)(1)(B) to reflect the correct title of 19 TAC §100.1027.

The adopted amendments have no new procedural and reporting implications. Also, the adopted amendments have no new locally maintained paperwork requirements.

The TEA determined that the amendments will have no adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

The public comment period began December 5, 2008, and ended January 5, 2009. In response to a request for a public hearing, the TEA held a public hearing on February 12, 2009, in Austin, Texas, to receive public comments on the proposed amendments. Following is a summary of public comments received and corresponding agency responses regarding the proposed amendments to 19 TAC Chapter 100, Charters, Subchapter AA, Commissioner's Rules Concerning Open-Enrollment Charter Schools.

Comment. An attorney with Feldman, Rogers, Morris & Grover, L.L.P. stated that the agency is statutorily prohibited from sanctioning charter schools on the basis of Performance-Based Monitoring Analysis System (PBMAS) monitoring reports; that the enabling statute of TEC, §7.028, does not apply to charter schools operated by 501(c)(3) corporations; that the agency is prohibited in its own rules from applying closure or taking other actions based on PBMAS ratings; and that the enabling statute, TEC, §7.028, authorizes the agency to conduct only a monitor-

ing and data-improvement program, not a performance-based ratings program.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. The current rule text was adopted on April 6, 2005. *See* 30 TexReg 1911. At the time it was adopted, the existing text cross-referenced then TEC, §7.027(a). As noted by West Publishing on page 18 of the current *School Law Bulletin*, TEC, §7.028, was renumbered from TEC, §7.027, by the 79th Texas Legislature in 2005. *See* H.B. No. 2018, 79th R.S., ch. 728, eff. Sept. 1, 2005. The proposed rule change simply updates the cross reference.

Comment. The chief executive officer (CEO) of Pegasus Charter School stated that the proposed changes would have a greater impact than to correct clerical errors. The commenter stated that the changes were an attempt by the agency to deny or revoke a charter based on performance-based monitoring (PBM) results, not on the academic performance of students. The commenter also stated that there is no opportunity to present mitigating circumstances in response to PBM findings. The commenter added that there needs to be a process so that the collection of data and the institution of an improvement plan operate in tandem so that schools that are making progress do not move to the next level of PBM intervention.

Agency Response. The agency disagrees in part, and cannot address the comment in part. In part, the comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The school director of Lindsley Park Community School stated that there were helpful consequences of PBMAS interventions but also some unintended and unhelpful consequences. The commenter stated that there is a small-number bias that can lead to a huge swing of great consequences based on one child. The commenter recommended rethinking the submission requirements for local education agencies with very small populations; holding districts accountable without such a tedious, time-consuming, and largely unhelpful submission process; and keeping the Continuous Improvement Plan.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The superintendent of Southwest Schools stated that while the TEA must comply with No Child Left Behind requirements, the current monitoring system is oppressive and duplicative as it is under two different TEA divisions. The commenter asked why there are two separate monitoring systems and why there is no effort to reconcile the different adequate yearly progress monitoring systems. The commenter stated that the remedial interventions increase only due to data input errors. The commenter also mentioned that there is no formal appeals process, which amounts to sanctions and the inappropriate application of a one-size-fits-all formula to special schools and special programs that are otherwise accommodated under other state and federal accreditation and accountability systems.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. An individual stated that there are problems with specific PBMAS indicators. Indicator #9 addresses special education dropout rates. The individual stated that students at a number of charter schools have already dropped out of district schools before enrolling in charter schools, so the stigma of being labeled a dropout is gone. Once a dropout enrolls in a charter school, the dropout is removed as a dropout from the school district's leaver code submissions. The individual suggested that the solution to this problem may be that a student who has previously dropped out of a traditional school and then drops out of a charter school be returned to the dropout list of the previous school district. The individual stated that the manner in which charter schools are required to submit data for this indicator does not allow them to explain anything about the student and does not address any quality factors about the programs being provided to these students in an effort to keep them in school.

The individual stated that Indicator #10 addresses the diploma program, and the level should not affect the charter school. The individual stated that charter schools that graduate students from special education should be given extra credit.

The individual also stated that Indicator #12 addresses special education identification and suggested that, rather than using the snapshot date to capture the data, a more accurate process would be to look at the total number of general education students served from the first day of school in August to the last day of school and divide that into the total number of special education students served throughout the same period. The individual indicated that the information submitted through the Texas Education Agency Secure Environment (TEA SE) system asks questions about the number of special education initial referrals and evaluations for the past school year, while the PBMAS system asks for the number of students served in the special education program. The individual stated that PBMAS may indicate too high a percentage of students in special education, even if none of these students were referred, evaluated, and placed in special education by the school.

Finally, the individual stated that TEC, Chapter 12, very clearly states that one of the original purposes of creating charter schools was to also create a new form of accountability for public schools, and that this should be a system that is fair and equitable to charter schools and gives consideration to the population of students these schools serve. The individual asked that the agency review the various reporting requirements, methods of evaluation, and standards for charter schools.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The superintendent of George I. Sanchez stated that PBMAS should focus on improvements, not sanctions, and that PBMAS is based on the standard accountability system, not the alternative accountability system. The commenter stated that immigrant children take, on average, three years to learn English. The commenter also mentioned that results of a monitoring visit were not shared until long after the visit. The commenter concluded by stating that interventions need to focus on helping

the charter schools get better and helping more students graduate.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The superintendent of Trinity Charter Schools stated that Trinity Charter Schools want to be held accountable. The commenter also mentioned that Trinity Charter Schools have *Academically Acceptable* ratings at all campuses and that they do not get to choose their students. The students are assigned by Child Protective Services, Immigration and Naturalization Service, and Juvenile Justice Services. These students only stay at the charter school, on average, for six months, which triggers interventions. The commenter stated that the two mandated interventions for Trinity Charter Schools are not effective and cost an inordinate amount of time and money. The commenter indicated that three students inside the facility for unaccompanied minors illegally in the United States ran away during the night from the facility and triggered a mandated technical assistance team made up of the superintendent, assistant superintendent, principal, English language arts teacher, two direct-care staff, two community members, and a business representative. The commenter stated that this team must meet several times during the year, and no matter how hard the team works, it will not make a difference given the type of program and the type of student in this school. The commenter also stated that PBMAS shows Trinity Charter Schools as over-identifying at-risk students and poverty levels when the schools exclusively serve at-risk students who are all children of poverty. The commenter stated that no one appears to want the type of students who attend Trinity Charter Schools and asked that PBMAS not make work more difficult than it already is.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The superintendent of Bay Area Charter School stated that Bay Area Charter School caters to white, upper class students who have been unsuccessful in traditional schools. The commenter said that the dropout recovery program system does not take into account what Bay Area Charter School set out to do in 1998 and that PBMAS needs to acknowledge different charter school populations. The commenter also mentioned that students at Bay Area Charter School take longer to graduate and concluded by stating that the school is making a difference every day.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The principal of Bay Area Charter Elementary stated that children come to the school with different needs and that a one-size-fits-all monitoring system does not work.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The superintendent of Phoenix Charter School stated that PBMAS costs money and time and that the interventions are answered with ineffective action plans. The commenter said time and money are spent on something that is not preventable and that this may affect the accreditation and existence of the school. The commenter also stated that charter schools attract students with problems and the focus needs to be on helping charter schools, not on action plans for problems that are not preventable.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The campus director of Temple Education Center stated that by virtue of being open-enrollment the school must allow enrollment to all students. The commenter said that Temple Education Center gets a large of number of students already identified as special education students and that very few students are identified at the school as special needs. The commenter asked that the special education indicator be studied to see if there is a way to prevent a school from being penalized for doing what it is supposed to do. The commenter stated that another problem charter schools face is the fact that students are often ordered by a court to get a GED, but those students are counted as dropouts. The commenter asked that charter schools stop being held accountable for these students.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The CEO of The Education Center and Temple Education Center stated that PBMAS requires much time on a continual basis and that report dates are hard to find and manage. The commenter stated that PBMAS has indicated that The Education Center and Temple Education Center have too many students taking the Texas Assessment of Knowledge and Skills (TAKS)-Alternate and not enough taking TAKS-Modified. The commenter stated that District Effectiveness and Compliance (DEC) visits may have been less confusing than PBMAS. The commenter further stated that the special education indicator is confusing because it states that a certain percentage of students receiving special education services must be assigned to take the TAKS (Accommodated). The commenter indicated that charter schools are instructed by special education staff at the TEA to do that which is best for the student, and then the schools are faced with accounting for the reason that they did so.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The principal of Austin Can! Academy Charter School stated that there was too much time being put into paperwork and not enough into children. The commenter also stated that PBM has not been shown to positively affect the academic performance of students.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The superintendent of John H. Wood Charter School stated a concern about the standards affecting charter schools. The commenter said that all students at John H. Wood are in lockdown of some sort, 75 percent are minority, and 40 percent are special education. The commenter stated that charter schools serve higher numbers of at-risk, minority, and special education students and that this has to be taken into account; that charter schools are smaller and take longer to recover from sanctions; and that charter schools can improve. The commenter concluded by saying that there should not be higher standards for charter schools and that the unique circumstances of charter schools need to be taken into account.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The CEO and founder of Focus Learning Academy stated that the zip code in which Focus Learning Academy is located has one of the highest crime rates in its city. The commenter mentioned that 100 percent of the students are minority, 90 percent are economically disadvantaged, and 40 percent are special education. The commenter stated that Focus Learning Academy was designed for special needs students and commented that PBMAS has indicated that the school has a disproportionate number of African-American students. The commenter stated that this causes extra work and uses resources to complete reports that could be used to help children instead. The commenter concluded by saying that the only way for the school not to have issues under PBMAS would be to stop serving these students.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The director and founder of Erath Excels stated that the school's charter was written to help dropouts and that the mission is to do what is best for students. The commenter stated that PBMAS has indicated that Erath Excels has too many special education students, but it would be illegal not to enroll them. The commenter also stated that PBMAS could be a problem for the school's campus in a residential treatment center.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The superintendent of Positive Solutions Charter School stated that small numbers trigger PBMAS and that going back to look at past numbers for charter schools does not work. The commenter stated that PBMAS has indicated that Positive Solutions Charter School has too many Hispanic special education students. The commenter mentioned that students have a choice to come to the school, but they also have a choice to return to the school district or go to another charter school. The commenter also stated a concern about the high mobility rate of students at the school.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The CEO of Shekinah Academy of Learning and Shekinah Radiance questioned the validity of PBMAS and what it actually addresses. The commenter said that she became involved with charter schools to help special needs students. The commenter concluded by stating that PBMAS needs to be reevaluated to determine whether it is valid for what it was designed to measure.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The director of the Shekinah Special Education Co-op stated a concern with Indicator #13, which involves over-representation of African-American students. The commenter stated that a lot of time is spent gathering information just for this indicator, and this time could be spent helping students instead.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The superintendent of Winfree Academy Charter School stated that PBMAS and PBM should not apply to charter schools. The commenter also mentioned that punishment should not be given to charter schools that reach out to highly at-risk children by accelerating graduation under a minimum graduation plan rather than allowing students to just drop out. The commenter added that PBM standards do not align with the accountability system. The commenter stated that students who drop out of regular schools will join a charter school, drop out, and have that count as a charter school dropout, reenroll in the same charter school, and drop out repeatedly, each time counting against the charter school as a dropout. The commenter stated that charter schools were designed to serve at-risk children and asked that the rules not be revised regarding PBMAS to penalize charter schools.

Agency Response. The agency cannot address the comment. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

Comment. The founder and director of Rise Academy stated that charter schools can be punished for serving the students targeted in their charter contract. The commenter added that PBMAS compliance consumes time and resources when the indicators have no bearing on the proper functioning of the charter school in terms of student achievement, financial integrity, or factors causing noncompliance that cannot be changed. The commenter also indicated that corrective actions such as stakeholder meetings and public forums do not address noncompliance such as data errors. The commenter concluded by stating

that PBMAS is not meant to close or punish charter schools, but the proposed rule change would strengthen TEA's ability to do so.

Agency Response. The agency disagrees in part, and cannot address the comment in part. The comment addresses issues outside the scope of the current rule proposal. The proposed changes to 19 TAC §100.1022(d) and (f) simply update a statutory cross reference and do not alter the agency's authority to intervene with or impose sanctions upon a charter school. *(See* response to comment from Feldman, Rogers, Morris & Grover, L.L.P.)

DIVISION 1. GENERAL PROVISIONS

19 TAC §100.1011

The amendment is adopted under the TEC, Chapter 12, Subchapter D, which authorizes the commissioner of education to adopt rules and procedures related to the implementation of open-enrollment charter schools.

The adopted amendment implements the TEC, Chapter 12, Subchapter D.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 2, 2009.

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Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
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For further information, please call: (512) 475-1497

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DIVISION 2. COMMISSIONER ACTION AND INTERVENTION

19 TAC §§100.1022, 100.1023, 100.1031

The amendments are adopted under the TEC, Chapter 12, Subchapter D, which authorizes the commissioner of education to adopt rules and procedures related to the implementation of open-enrollment charter schools.

The adopted amendments implement the TEC, Chapter 12, Subchapter D.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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DIVISION 3. CHARTER SCHOOL FUNDING AND FINANCIAL OPERATIONS

19 TAC §100.1047

The amendment is adopted under the TEC, Chapter 12, Subchapter D, which authorizes the commissioner of education to adopt rules and procedures related to the implementation of open-enrollment charter schools.

The adopted amendment implements the TEC, Chapter 12, Subchapter D.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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DIVISION 5. CHARTER SCHOOL GOVERNANCE

19 TAC §100.1155

The amendment is adopted under the TEC, Chapter 12, Subchapter D, which authorizes the commissioner of education to adopt rules and procedures related to the implementation of open-enrollment charter schools.

The adopted amendment implements the TEC, Chapter 12, Subchapter D.

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TITLE 22. EXAMINING BOARDS

PART 9. TEXAS MEDICAL BOARD

CHAPTER 162. SUPERVISION OF MEDICAL SCHOOL STUDENTS

22 TAC §162.1

The Texas Medical Board (Board) adopts amendments to Chapter 162, §162.1, concerning Supervision of Medical Students,

without changes to the proposed text as published in the May 1, 2009, issue of the *Texas Register* (34 TexReg 2668) and will not be republished.

The Board sought stakeholder input through Stakeholder Groups, which made comments on the suggested changes to the rule at a meeting held on October 29, 2008. The comments were incorporated into the proposed rule.

The amendment clarifies the intent of the amendment previously adopted based on Stakeholder input, which became effective on March 9, 2009. The Board determined that the revised language was necessary based on questions received regarding interpretation.

The Board received no public written comments and no one appeared to testify at the public hearing held on May 29, 2009.

The amendment is adopted under the authority of the Texas Occupations Code Annotated, §153.001 and §154.006, which provide authority for the Board to adopt rules and bylaws as necessary to govern its own proceedings, perform its duties, regulate the practice of medicine in this state, enforce this subtitle, and establish rules related to licensure.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 4, 2009.

TRD-200902225
Mari Robinson, J.D.
Interim Executive Director
Texas Medical Board
Effective date: June 24, 2009
Proposal publication date: May 1, 2009
For further information, please call: (512) 305-7016

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CHAPTER 165. MEDICAL RECORDS

22 TAC §165.3

The Texas Medical Board (Board) adopts amendments to Chapter 165, §165.3, concerning Patient Access to Diagnostic Imaging Studies in Physician's Office, without changes to the proposed text as published in the May 1, 2009, issue of the *Texas Register* (34 TexReg 2669) and will not be republished.

The amendment expands the rule to include non-static diagnostic imaging studies and imaging studies that are maintained in electronic format.

The Board determined that the rule change was necessary to clarify the definition of diagnostic imaging studies for the purpose of releasing such records to requestors for medical records.

The Board received no public written comments and no one appeared to testify at the public hearing held on May 29, 2009.

The amendment is adopted under the authority of the Texas Occupations Code Annotated, §153.001 and §154.006, which provide authority for the Board to adopt rules and bylaws as necessary to govern its own proceedings, perform its duties, regulate the practice of medicine in this state, enforce this subtitle, and establish rules related to licensure.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 305-7016

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CHAPTER 173. PHYSICIAN PROFILES

22 TAC §173.1

The Texas Medical Board (Board) adopts amendments to Chapter 173, §173.1, concerning Profile Contents, without changes to the proposed text as published in the May 1, 2009, issue of the *Texas Register* (34 TexReg 2670) and will not be republished.

The Board sought stakeholder input through Stakeholder Groups, which made comments on the suggested changes to the rule at a meeting held on October 29, 2008. The comments were incorporated into the proposed rule.

The amendment requires that the profile of each licensed physician shall contain the physician's full name as the physician is licensed. The Board determined that the change was necessary to allow the Board to appropriately track all physicians licensed by the Board rather than allowing physicians to identify themselves under multiple names when submitting documents to the Board.

The Board received no public written comments and no one appeared to testify at the public hearing held on May 29, 2009.

The amendment is adopted under the authority of the Texas Occupations Code Annotated, §153.001 and §154.006, which provide authority for the Board to adopt rules and bylaws as necessary to govern its own proceedings, perform its duties, regulate the practice of medicine in this state, enforce this subtitle, and establish rules related to licensure.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 305-7016

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CHAPTER 190. DISCIPLINARY GUIDELINES
SUBCHAPTER B. VIOLATION GUIDELINES

22 TAC §190.8

The Texas Medical Board (Board) adopts amendments to Chapter 190, §190.8, concerning Violation Guidelines, without changes to the proposed text as published in the March 27, 2009, issue of the *Texas Register* (34 TexReg 2671) and will not be republished.

Elsewhere in this issue of the *Texas Register,* the Board contemporaneously withdraws the emergency amendment to §190.8, which was published in the March 27, 2009, issue of the *Texas Register* (34 TexReg 2071). The withdrawal becomes effective June 24, 2009, which is the same date this amendment becomes effective.

The Board sought stakeholder input through Stakeholder Groups, which made comments on the suggested changes to the rule at a meeting held on October 29, 2008. The comments were incorporated into the proposed rule.

The amendment to §190.8 adds an exception to the requirement in paragraph (1)(L) that a physician may only prescribe drugs to a person with whom a proper professional relationship has been established, for the prescription of drugs for a partner of a patient who may have a sexually transmitted disease.

The Board has determined that the amendment to the rule addresses a serious public health issue and is intended to allow physicians to treat persons with sexually transmitted diseases as early as possible or prevent such persons from contracting sexually transmitted diseases from their partners.

The Board received public written comments; however, no one appeared to testify at the public hearing held on May 29, 2009.

The Board received a written comment from one individual with the Corpus Christi Nueces Public Health District. The comment was that nurses would be the actual persons prescribing the medication to the partners of patients with sexually transmitted diseases and therefore be held liable if the persons had adverse side effects to the medications. The Board determined that the prescribing by midlevel practitioners under the amendment would occur through a physician-delegated act under written standing delegation orders so that a physician will retain liability if the protocols are followed.

The amendment is adopted under the authority of the Texas Occupations Code Annotated, §153.001 and §154.006, which provide authority for the Board to adopt rules and bylaws as necessary to govern its own proceedings, perform its duties, regulate the practice of medicine in this state, enforce this subtitle, and establish rules related to licensure.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Mari Robinson, J.D.
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Texas Medical Board
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For further information, please call: (512) 305-7016

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 139. ABORTION FACILITY REPORTING AND LICENSING

The Executive Commissioner of the Health and Human Services Commission (commission) on behalf of the Department of State Health Services (department) adopts the repeal of §§139.1 - 139.8, 139.21 - 139.25, 139.31 - 139.33, and 139.41 - 139.60 and new §§139.1 - 139.8, 139.21 - 139.25, 139.31 - 139.33, and 139.41 - 139.60, concerning the regulation of abortion facilities. New §§139.2, 139.6, 139.8, 139.23, 139.46 - 139.49, 139.51, 139.53, 139.54, 139.57, and 139.59 are adopted with changes to the proposed text as published in the December 19, 2008, issue of the *Texas Register* (33 TexReg 10269). The repeal of §§139.1 - 139.8, 139.21 - 139.25, 139.31 - 139.33, and 139.41 - 139.60 and new §§139.1, 139.3 - 139.5, 139.7, 139.21, 139.22, 139.24, 139.25, 139.31 - 139.33, 139.41 - 139.45, 139.50, 139.52, 139.55, 139.56, 139.58 and 139.60 are adopted without changes and, therefore, the sections will not be republished.

BACKGROUND AND PURPOSE

The repeals and new sections are necessary to update and clarify the rules. Government Code, §2001.039, requires that each state agency review and consider for readoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 139.1 - 139.8, 139.21 - 139.25, 139.31 - 139.33, and 139.41 - 139.60 have been reviewed and the department has determined that reasons for adopting the sections continue to exist because rules on this subject are needed.

SECTION-BY-SECTION SUMMARY

New §§139.1 - 139.8, 139.21 - 139.25, 139.31 - 139.33, and 139.41 - 139.60 provide clarification to the rules and update references to statutes and rules, the names and contact information of boards, the department and its programs. The new §139.2 deletes definitions not used in the rules, adds the definitions of advanced practice nurse, fetus, medical abortion, physician assistant, and surgical abortion, and revises the definitions of certified registered nurse anesthetist, director, licensed vocational nurse, physician, and registered nurse. The new §§139.21 - 139.23 delete references to certain dates. The new §139.49 clarifies the use of steam sterilizers. The new §139.50 and §139.52 clarify that disclosure, patient education and information services are to be provided to a woman on whom the abortion is to be performed. The new §139.54 deletes language concerning the scope of practice for licensed vocational nurses and changes nursing services to licensed health care professionals. The new §139.55 requires a preanesthesia evaluation by personnel approved to provide anesthesia services. The new §139.59 revises anesthesia services using language similar to the ambulatory surgical center rules for consistency.

COMMENTS

The department, on behalf of the commission, has reviewed and prepared responses to the comments received regarding the proposed rules during the comment period, which the commission has reviewed and accepts. The commenters were individuals, associations, and/or groups, including the following: Texas Association of Nurse Anesthetists, Texas Society of Anesthesiologists, Whole Woman's Health, LLC, Society of Diagnostic Medical Sonography, Texas Association of Planned Parenthood

Affiliates, and Texas Alliance for Life. The commenters were not against the rules in their entirety; however, the commenters suggested recommendations for change as discussed in the summary of comments.

Comment: Concerning Chapter 139, one commenter suggested a requirement for mandatory credentialing of sonographers to include minimum education standards for credentialing, and sonography laboratory accreditation.

Response: The commission disagrees. Section 139.46(4) provides that the requirements and qualifications for training and experience of ancillary staff are prescribed by the facility administrator and the medical consultant as needed. Section 139.41(a) provides that the licensee is responsible for "developing, implementing, enforcing, and monitoring written policies governing the facility's total operation, and for ensuring that these policies comply with the Act and the applicable provisions of this chapter and are administered so as to provide health care in a safe and professionally acceptable environment." Section 139.41(a)(2) specifically references "clinical policies governing medical and clinical practices and procedures of the facility." No change has been made to the rule as a result of this comment.

Comment: Concerning Chapter 139, one commenter suggested adding a requirement that any abortion performed on a minor require the written, notarized consent of a parent as required by the Board of Medical Examiners.

Response: The commission disagrees. Parental consent for an abortion performed on a minor is not required under certain circumstances as set out in Family Code, Chapter 33. The suggested requirement would be in conflict with existing law. No change has been made to the rule as a result of this comment.

Comment: Concerning §139.1(b), one commenter requests that entities that advertise they perform abortions should be required to obtain a license as an abortion facility.

Response: The commission disagrees. The Health and Safety Code, §245.004, sets out exemptions from licensing which include (1) a hospital licensed under Chapter 241 (Texas Hospital Licensing Law); (2) the office of a physician licensed under Subtitle B, Title 3, Occupations Code, unless the office is used for the purpose of performing more than 50 abortions in any 12-month period; or (3) an ambulatory surgical center licensed under Chapter 243. No change has been made to the rule as a result of this comment.

Comment: Concerning §139.2(5) and (10), 139.6(e), 139.8(b)(2), 139.23(c)(2)(C)(x), 139.46(3)(A), 139.53(a)(4), (8), (9), (b)(5), 139.54(a)(2), and 139.57(a)(2)(C), one commenter requested that the term "advanced practice nurse" be changed to "advanced practice registered nurse" throughout the proposed rules to agree with amendments to the Texas Board of Nursing rules adopted on November 14, 2008.

Response: The commission agrees with the commenter and has replaced the term "advanced practice nurse" with "advanced practice registered nurse."

Comment: Concerning §139.2(10), one commenter requested that the words "currently licensed" and "authorized" be deleted to remove redundancy from the definition.

Response: The commission agrees with the commenter and has deleted "currently licensed," but disagrees that "authorized" be deleted because the term "authorized" is in agreement with 22 Texas Administrative Code, Part 11, Chapter 221, §221.2.

Comment: Concerning §139.2(30) and (52), one commenter states that there should be only one definition of abortion and cites the statute Health and Safety Code, Chapter 245, which has only a single definition of abortion and does not distinguish between surgical and medical methods of abortion.

Response: The commission disagrees. The general definition of abortion is provided in §139.2(1), which does not distinguish between surgical and medical methods of abortion. The two distinct types of abortions available require differentiation and specific regulatory requirements to protect the health and safety of patients, hence the addition of the definitions in §139.2(30) and (52). No change has been made to the rule as a result of this comment.

Comment: Concerning §139.48(1)(C) and (2), and §139.49, one commenter proposes that facilities that perform only medication abortion be exempted from these requirements.

Response: Concerning §139.48(1)(C), the commission agrees that facilities that do not administer moderate sedation/analgesia, deep sedation/analgesia or general anesthesia do not require a separate recovery room and has added "if moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia are administered at the facility." Concerning §139.48(2), the commission agrees and has added "in facilities that provide vacuum aspiration." Equipment for vacuum aspiration should be electrically safe and designed to prevent reverse pump action. The standard applies to any facility that performs vacuum aspiration. Concerning §139.49, the commission disagrees that an abortion facility would be exempted from the entire section regarding infection control standards. Concerning §139.49(d)(2), the commission agrees that facilities performing only medical abortions should not be required to ensure that surgical instruments are available for performing conventional cervical dilatation and curettage and has added "if this procedure is available at the facility."

Comment: Concerning §139.53(a)(5)(A) and (B), and §139.55(c)(5), one commenter stated that the effect of the current proposal would be to authorize registered nurses to perform preanesthesia evaluations of patients for anesthesia risk factors. The evaluation of a patient for risks associated with anesthesia should be performed by a physician, and the proposed language compromises patient safety.

Response: The commission disagrees with the commenter. These rules address the responsibilities of the person administering anesthesia and do not compromise patient safety. In addition to the pre-anesthesia evaluation, the rule at §139.59(e) requires the physician to evaluate the patient immediately prior to the procedure to assess the risk of the anesthesia and of the procedure to be performed. No change has been made to the rule as a result of this comment.

Comment: Concerning §139.53(a)(10), one commenter suggested that "available" be defined as able to be physically present in the facility to assume responsibility for the delivery of patient care services within five minutes.

Response: The commission disagrees with the commenter. This would be a substantive change to the proposed rules. The scope of service delivery in an abortion facility is extremely limited in comparison with an ambulatory surgical center or hospital and incorporating such a requirement would necessitate extensive research and stakeholder input. No change has been made to the rule as a result of this comment.

Comment: Concerning §139.59, one commenter proposes that no changes should be made to the abortion facilities anesthesia services requirements as it would impose onerous ambulatory surgical center anesthesia requirements on abortion facilities.

Response: The commission agrees that with the advent of medical abortions, some changes to §139.59 are warranted and have been made. Sections 139.59(a), (b), (d), (d)(4), (e), (f) and (j)(2)(E) were revised with regard to facilities which do not administer moderate sedation/analgesia, deep sedation/analgesia or general anesthesia and are specifically addressed in the following comments.

Comment: Concerning §139.59(a), one commenter suggested that topical, local and minimal anesthesia be excluded from the regulations of anesthesia services for purposes of staffing or patient monitoring.

Response: The commission disagrees. Section 139.59(c) states that the facility medical staff develops written policies and practice guidelines for the anesthesia service in accordance with standards, guidelines, and applicable licensing rules. No change has been made to the rule as a result of this comment.

Comment: Concerning §139.59(b), one commenter states there is no need for an "anesthesia department" in abortion facilities utilizing minimal or moderation sedation.

Response: The commission agrees and has deleted "the" and added "an" in reference to "anesthesia department," and has added the phrase "required if moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia are administered at the facility and shall be." The commission has added the word "when" to §139.59(a) to read "Anesthesia services when provided in the abortion facility shall be limited to those that are approved by the governing body, which may include the following."

Comment: Concerning §139.59(d), one commenter suggested adding the words "or CRNA" as a CRNA may need to direct a registered nurse to administer a sedative drug during surgery.

Response: The commission agrees and has added the words "or CRNA."

Comment: Concerning §139.59(d)(4), one commenter states that the requirement for the registered nurse to have no other duties except to monitor the patient is unnecessary and unreasonable as applied to certain types of minimal sedation used in abortion procedures, such as a one-time dose of ibuprofen (or similar analgesic medication) and diazepam (or similar oral sedative) which do not require the level of training of a registered nurse. The commenter suggests that certain types of minimal sedation commonly used in abortion procedures can be administered by a qualified individual for the unsupervised treatment of anxiety or pain.

Response: The commission agrees and has added the term "moderate" to indicate that a registered nurse who is not a CRNA shall "ensure that, when administering moderate sedation during a procedure, the registered nurse has no other duties except to monitor the patient." Per §139.59(d)(1) - (3), the facility is required to verify that the registered nurse administering sedation has the requisite training, education, and experience; to maintain documentation to support that the registered nurse has demonstrated competency in the administration of sedation; and to develop, implement and enforce detailed, written policies and procedures to guide the registered nurse. Per the Nurse Practice Act of 22 Texas Administrative Code, Part 11, §217.11, the registered nurse must comply with and is responsible to (B) Implement measures to promote a safe environment for clients and others; (C) Know the rationale for and the effects of medications and treatments and shall correctly administer the same; and (M) Institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications.

Comment: Concerning §139.59(e), one commenter requested that the rule be changed to require the physician, an anesthesiologist, or the certified registered nurse anesthetist (CRNA) who will be administering the anesthesia to evaluate the patient immediately prior to the procedure to assess the risk of anesthesia relative to the procedure to be performed. One of the commenters requested the term "physician" be changed to "operating surgeon."

Response: The commission disagrees with the commenter as the rule requires the physician to evaluate the patient immediately prior to the procedure to assess the risk of the anesthesia and to assess the risk of the procedure to be performed. The commission agrees with the commenter to change "physician" to "operating surgeon."

Comment: Concerning §139.59(f), two commenters requested that "CRNA" be added to the list of personnel required to be available until all of his or her patients operated on that day have been discharged to the recovery room.

Response: The commission agrees with the commenter and has added "CRNA."

Comment: Concerning §139.59(j)(2)(D), one commenter suggested that the requirement for electrocardiographic monitoring equipment in abortion facilities using moderate sedation is unnecessary.

Response: The commission disagrees. Section 139.59(j)(2)(D) states that facilities that provide sedation, to include moderate sedation/analgesia, deep sedation/analgesia, regional analgesia and/or general anesthesia require electrocardiographic monitoring equipment. No change has been made to the rule as a result of this comment.

Comment: Concerning §139.59(j)(2)(E), one commenter suggested that the requirement for cardiovertor-defibrillator equipment in abortion facilities using moderate sedation is unnecessary.

Response: The commission agrees and has deleted the term "cardiovertor-defibrillator" and has added the term "cardiac defibrillator" to enable facilities to determine the type of defibrillator appropriate for the type of anesthesia services provided at the facility.

Comment: Concerning §139.59(j)(2)(E), one commenter clarified the difference between a cardiovertor-defibrillator (implantable device) and a cardioversion-defibrillator (used in advanced cardiopulmonary resuscitation). The commenter suggested that the requirement for cardiovertor-defibrillator equipment in abortion facilities using moderate sedation is unreasonable. The commenter proposed either (a) only an AED (automated external defibrillator) or (b) a cardioversion-defibrillator or an AED at facilities that provide only moderate sedation.

Response: The commission agrees and has deleted "cardiovertor-defibrillator" and has added "cardiac defibrillator" to enable facilities to determine the type of defibrillator related to specific anesthesia services provided at the facility.

The following changes have been made to correct errors and provide consistency of terms.

Change: Concerning §139.2(38), the agency name "Texas State Board of Physician Assistant Examiners" was corrected to "Texas Physician Assistant Board."

Change: Concerning §139.47(b)(2), the words "color, sex, or disability" were added for consistency concerning the employment of personnel.

Change: Concerning §139.51(6), the word "creed" was deleted and the words "color, age, sex, religion or disability" were added for consistency concerning women's access to care and treatment.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the rules, as adopted, have been reviewed by legal counsel and found to be a valid exercise of the agencies' legal authority.

SUBCHAPTER A. GENERAL PROVISIONS

25 TAC §§139.1 - 139.8

STATUTORY AUTHORITY

The repeals are authorized by Health and Safety Code, §245.009, concerning rules and minimum standards to protect and promote the public health and welfare by providing for the issuance, renewal, denial, suspension, and revocation of each license; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 8, 2009.

TRD-200902279
Lisa Hernandez
General Counsel
Department of State Health Services
Effective date: June 28, 2009
Proposal publication date: December 19, 2008
For further information, please call: (512) 458-7111 x6972

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25 TAC §§139.1 - 139.8

STATUTORY AUTHORITY

The new rules are authorized by Health and Safety Code, §245.009, concerning rules and minimum standards to protect and promote the public health and welfare by providing for the issuance, renewal, denial, suspension, and revocation of each license; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

§139.2. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Abortion--The use of any means to terminate the pregnancy of a female known by the attending physician to be pregnant, with the intention that the termination of the pregnancy by those means will, with reasonable likelihood, cause the death of the fetus. The term does not include birth control devices or oral contraceptives. An abortion may be performed only by a physician licensed to practice medicine in this state.

(2) Abortion facility--A place where abortions are performed.

(3) Act--Texas Abortion Facility Reporting and Licensing Act, Health and Safety Code, Chapter 245.

(4) Administrator--A person who:

(A) is delegated the responsibility for the implementation and proper application of policies, programs, and services established for the licensed abortion facility; and

(B) meets the qualifications established in §139.46(2) of this title (relating to Licensed Abortion Facility Staffing Requirements and Qualifications).

(5) Advanced practice registered nurse (APRN)--A registered nurse approved by the Texas Board of Nursing to practice as an advanced practice registered nurse on the basis of completion of an advanced educational program. The term includes a nurse practitioner, nurse midwife, nurse anesthetist, and clinical nurse specialist. The term is synonymous with "advanced nurse practitioner."

(6) Affidavit--A written statement, sworn to or affirmed, and witnessed by a witness whose signature and printed name appears on the affidavit. "Notarized affidavit" in these rules means an affidavit in which the statement is witnessed by a notary acting pursuant to Government Code, Chapter 406.

(7) Affiliate--With respect to an applicant or owner which is:

(A) a corporation--includes each officer, consultant, stockholder with a direct ownership of at least 5.0%, subsidiary, and parent company;

(B) a limited liability company--includes each officer, member, and parent company;

(C) an individual--includes:

(i) the individual's spouse;

(ii) each partnership and each partner thereof of which the individual or any affiliate of the individual is a partner; and

(iii) each corporation in which the individual is an officer, consultant, or stockholder with a direct ownership of at least 5.0%;

(D) a partnership--includes each partner and any parent company; and

(E) a group of co-owners under any other business arrangement--includes each officer, consultant, or the equivalent under the specific business arrangement and each parent company.

(8) Ambulatory surgical center--An ambulatory surgical center licensed under Health and Safety Code, Chapter 243.

(9) Applicant--The owner of an abortion facility which is applying for a license under the Act. For the purpose of this chapter, the word "owner" includes nonprofit organization.

(10) Certified registered nurse anesthetist (CRNA)--A registered nurse who has current certification from the Council on Certification of Nurse Anesthetists and who is currently authorized to practice as an advanced practice registered nurse by the Texas Board of Nursing.

(11) Change of ownership--A sole proprietor who transfers all or part of the facility's ownership to another person or persons; the removal, addition, or substitution of a person or persons as a partner in a facility owned by a partnership; or a corporate sale, transfer, reorganization, or merger of the corporation which owns the facility if sale, transfer, reorganization, or merger causes a change in the facility's ownership to another person or persons.

(12) Condition on discharge--A statement on the condition of the patient at the time of discharge.

(13) Critical item--All surgical instruments and objects that are introduced directly into the bloodstream or into other normally sterile areas of the body.

(14) Decontamination--The physical and chemical process that renders an inanimate object safe for further handling.

(15) Department--The Department of State Health Services.

(16) Director--The director of the Patient Quality Care Unit of the department or his or her designee.

(17) Disinfection--The destruction or removal of vegetative bacteria, fungi, and most viruses but not necessarily spores; the process does not remove all organisms but reduces them to a level that is not harmful to a person's health. There are three levels of disinfection:

(A) high-level disinfection--kills all organisms, except high levels of bacterial spores, and is effected with a chemical germicide cleared for marketing as a sterilant by the United States Food and Drug Administration;

(B) intermediate-level disinfection--kills mycobacteria, most viruses, and bacteria with a chemical germicide registered as a "tuberculocide" by the United States Environmental Protection Agency (EPA); and

(C) low-level disinfection--kills some viruses and bacteria with a chemical germicide registered as a hospital disinfectant by the EPA.

(18) Education and information staff--A professional or nonprofessional person who is trained to provide information on abortion procedures, alternatives, informed consent, and family planning services.

(19) Facility--A licensed abortion facility as defined in this section.

(20) Fetus--An individual human organism from fertilization until birth.

(21) Health care facility--Any type of facility or home and community support services agency licensed to provide health care in any state or is certified for Medicare (Title XVIII) or Medicaid (Title XIX) participation in any state.

(22) Health care worker--Any person who furnishes health care services in a direct patient care situation under a license, certificate, or registration issued by the State of Texas or a person providing direct patient care in the course of a training or educational program.

(23) Hospital--A facility that is licensed under the Texas Hospital Licensing Law, Health and Safety Code, Chapter 241, or if exempt from licensure, certified by the United States Department of Health and Human Services as in compliance with the conditions of participation for hospitals in Title XVIII, Social Security Act (42 United States Code, §§1395 et. seq.).

(24) Immediate jeopardy to health and safety--A situation in which there is a high probability that serious harm or injury to patients could occur at any time or already has occurred and may well occur again, if patients are not protected effectively from the harm or if the threat is not removed.

(25) Inspection--An on-site inspection by the department in which a standard-by-standard evaluation is conducted.

(26) Licensed abortion facility--A place licensed by the department under Health and Safety Code, Chapter 245, where abortions are performed.

(27) Licensed mental health practitioner--A person licensed in the State of Texas to provide counseling or psychotherapeutic services.

(28) Licensed vocational nurse (LVN)--A person who is currently licensed by the Texas Board of Nursing as a licensed vocational nurse.

(29) Licensee--A person or entity who is currently licensed as an abortion facility.

(30) Medical abortion--The use of a medication or combination of medications to induce an abortion, with the purpose of terminating the pregnancy of a woman known to be pregnant. Medical abortion does not include forms of birth control.

(31) Medical consultant--A physician who is designated to supervise the medical services of the facility.

(32) Nonprofessional personnel--Personnel of the facility who are not licensed or certified under the laws of this state to provide a service and shall function under the delegated authority of a physician, registered nurse, or other licensed health professional who assumes responsibility for their performance in the licensed abortion facility.

(33) Noncritical items--Items that come in contact with intact skin.

(34) Notarized copy--A copy attached to a notarized affidavit which states that the attached copy(ies) are true and correct copies of the original documents.

(35) Patient--A pregnant female on whom an abortion is performed, but shall in no event be construed to include a fetus.

(36) Person--Any individual, firm, partnership, corporation, or association.

(37) Physician--An individual licensed by the Texas Medical Board and authorized to practice medicine in the State of Texas.

(38) Physician assistant--A person licensed as a physician assistant by the Texas Physician Assistant Board.

(39) Plan of correction--A written strategy for correcting a licensing violation. The plan of correction shall be developed by the facility, and shall address the system(s) operation(s) of the facility as the system(s) operation(s) apply to the deficiency.

(40) Post-procedure infection--An infection acquired at or during an admission to a facility; there shall be no evidence that the infection was present or incubating at the time of admission to the facility. Post-procedure infections and their complications that may occur after an abortion include, but are not limited to, endometritis and other infections of the female reproductive tract, laboratory-confirmed or clinical sepsis, septic pelvic thrombophlebitis, and disseminated intravascular coagulopathy.

(41) Pregnant unemancipated minor certification form--The document prepared by the Department of State Health Services and used by physicians to certify the medical indications supporting the judgment for the immediate abortion of a pregnant minor.

(42) Pre-inspection conference--A conference held with department staff and the applicant or his or her representative to review licensure standards, inspection documents, and provide consultation prior to the on-site licensure inspection.

(43) Professional personnel--Patient care personnel of the facility currently licensed or certified under the laws of this state to use a title and provide the type of service for which they are licensed or certified.

(44) Quality assurance--An ongoing, objective, and systematic process of monitoring, evaluating, and improving the appropriateness, and effectiveness of care.

(45) Quality improvement--An organized, structured process that selectively identifies improvement projects to achieve improvements in products or services.

(46) Registered nurse (RN)--A person who is currently licensed by the Texas Board of Nursing as a registered nurse.

(47) Semicritical items--Items that come in contact with nonintact skin or mucous membranes. Semicritical items may include respiratory therapy equipment, anesthesia equipment, bronchoscopes, and thermometers.

(48) Standards--Minimum requirements under the Act and this chapter.

(49) Sterile field--The operative area of the body and anything that directly contacts this area.

(50) Sterilization--The use of a physical or chemical procedure to destroy all microbial life, including bacterial endospores.

(51) Supervision--Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity that includes initial direction and periodic inspection of the actual act of accomplishing the function or activity.

(52) Surgical abortion--The use of instruments, aspiration, and/or suction to induce an abortion, with the purpose of terminating the pregnancy of a woman known to be pregnant.

(53) Third trimester certification form--The document prepared by the Department of State Health Services and used by physicians to certify the medical indications supporting the judgment for the abortion of a viable fetus during the third trimester of pregnancy.

(54) Third trimester--A gestational period of not less than 26 weeks (following last-menstrual period (LMP)).

(55) Unemancipated minor--A minor who is unmarried and has not had the disabilities of minority removed under the Family Code, Chapter 31.

§139.6. Public Information; Toll-Free Telephone Number.

(a) An abortion facility shall provide to a woman, at the time the woman initially consults the facility, a written statement indicating the number of the toll-free telephone number maintained under subsection (d) of this section. The written statement shall be available in English and Spanish.

(1) The following form is an example of the statement in English.
Figure: 25 TAC §139.6(a)(1)

(2) The following form is an example of the statement in Spanish.
Figure: 25 TAC §139.6(a)(2)

(b) The department on request shall make the following information available to the public:

(1) the status of the license of any abortion facility;

(2) the date of the last inspection of the facility, any violation discovered during that inspection that would pose a health risk to a patient at the facility, any challenge raised by the facility to the allegation that there was a violation, and any corrective action that is acceptable to the department and that is being undertaken by the facility with respect to the violation; and

(3) an administrative or civil penalty imposed against the facility or a physician who provides services at the facility, professional discipline imposed against a physician who provides services at the facility, and any criminal conviction of the facility or a physician who provides services at the facility that is relevant to services provided at the facility.

(c) Subsection (b) of this section does not require the department to provide information that is not in the possession of the department. In accordance with Health and Safety Code, §245.023(b), the Texas Medical Board (board) is required to provide to the department information in the possession of the board that the department is required to provide under subsection (b) of this section.

(d) In accordance with Health and Safety Code, §245.023(c), the department shall maintain a toll-free telephone number that a person may call to obtain the information described by subsection (b) of this section.

(e) This section does not authorize the department to the release of the name, address, or phone number of any employee or patient of an abortion facility or of a physician, advanced practice registered nurse, or physician assistant who provides services at an abortion facility.

§139.8. Quality Assurance.

(a) Quality Assurance (QA) Program. A licensed abortion facility shall maintain a QA program in the facility which shall be implemented by a QA committee. The QA program shall be ongoing and have a written plan of implementation. This plan shall be reviewed and updated or revised at least annually by the QA Committee. The QA program shall include measures for quality improvement in the measurement of the facility's delivery of service. Quality assurance documents pertinent to the facility shall be kept within the facility.

(b) QA committee membership. At a minimum, the QA committee shall consist of at least:

(1) the medical consultant designated by the facility;

(2) an advanced practice registered nurse, a physician assistant, a registered nurse, or a licensed vocational nurse; and

(3) at least two other members of the facility's staff.

(c) Frequency of QA committee meetings. The QA committee, by consensus, shall meet at least quarterly to identify issues with respect to which quality assurance activities are necessary.

(d) Minimum responsibilities. The QA committee shall:

(1) evaluate all organized services related to patient care, including services furnished by contract;

(2) ensure that there is a review of any abortion procedure complication(s), and shall make use of the findings in the development and revision of facility policies;

(3) address issues of unprofessional conduct by any member of the facility's staff (including contract staff);

(4) monitor infection control as outlined in §139.49 of this title (relating to Infection Control Standards) and post-procedure infections as outlined in §139.41 of this title (relating to Policy Development and Review);

(5) address medication therapy practices;

(6) address the integrity of surgical instruments, medical equipment, and patient supplies; and

(7) address services performed in the facility as they relate to appropriateness of diagnosis and treatment.

(e) Patient care and service issues. The QA committee shall identify and address patient care services and information issues and implement corrective action plans as necessary.

(1) Identifying issues that necessitate corrective action. The QA committee shall be responsible for identifying issues that necessitate corrective action by the committee, such as issues which negatively affect care or services provided to patients.

(2) Plan of corrective action. The QA committee shall develop and implement plans of action to correct identified deficiencies.

(3) Remedial action. The QA committee shall take and document remedial action to address deficiencies found through the QA program. The facility shall document the outcome of the remedial action.

(f) Departmental review.

(1) The department shall not use good faith efforts by the QA committee to identify and correct deficiencies as a basis for deficiency(ies), citation(s), or sanction(s).

(2) Department surveyors shall verify that:

(A) the facility has a QA committee which addresses concerns; and

(B) the facility staff know how to access that process.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. LICENSING PROCEDURES

25 TAC §§139.21 - 139.25

STATUTORY AUTHORITY

The repeals are authorized by Health and Safety Code, §245.009, concerning rules and minimum standards to protect and promote the public health and welfare by providing for the issuance, renewal, denial, suspension, and revocation of each license; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

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25 TAC §§139.21 - 139.25

STATUTORY AUTHORITY

The new rules are authorized by Health and Safety Code, §245.009, concerning rules and minimum standards to protect and promote the public health and welfare by providing for the issuance, renewal, denial, suspension, and revocation of each license; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

§139.23. Application Procedures and Issuance of Licenses.

(a) Purpose. This section establishes the application procedures that an abortion facility shall follow to obtain a license to operate as a licensed abortion facility in Texas.

(b) Definitions. The following terms when used in this section shall have the following meaning.

(1) Initial license--A license which is issued by the department to all first-time applicants for an abortion facility license, including those from unlicensed operating facilities and licensed facilities for which a change of ownership is anticipated, that meet the requirements of the Act and this chapter and have successfully completed the application procedures for an initial license as set out in subsection (c) of this section. Initial licenses shall expire in two years.

(2) Renewal license--A license issued by the department to a licensed abortion facility that meets all requirements of the Act and this chapter and has completed the application procedures for obtaining

a renewal license as set out in subsection (d) of this section. Renewal licenses shall expire in two years.

(c) Application procedures for an initial license. This subsection establishes the application procedures for obtaining an initial license.

(1) Request for an application. Upon request for an abortion facility license, the department shall furnish a person with an application packet. Applications may also be obtained and submitted through the department's web site.

(2) Application requirements. The applicant shall submit the information listed in subparagraph (C) of this paragraph to the department.

(A) An applicant shall not misstate a material fact on any documents required to be submitted under this subsection.

(B) The application form shall be accurate and complete and shall contain original signatures. The initial license fee shall accompany the application.

(C) The following documents shall be submitted with the original application form prescribed by the department and shall be originals or notarized copies:

(i) information on the applicant including name, street address, mailing address, social security number or franchise tax identification number, date of birth, and driver's license number;

(ii) the name, mailing address, and street address of the abortion facility. The address provided on the application shall be the address from which the abortion facility will be operating and providing services;

(iii) the telephone number of the facility, the telephone number where the administrator can usually be reached when the facility is closed, and if the facility has a fax machine, the fax number;

(iv) a list of names and business addresses of all persons who own any percentage interest in the applicant including:

(I) each limited partner and general partner if the applicant is a partnership; and

(II) each shareholder, member, director, and officer if the applicant is a corporation, limited liability company, or other business entity;

(v) a list of any businesses with which the applicant subcontracts and in which the persons listed under clause (iv) of this subparagraph hold any percentage of the ownership;

(vi) if the applicant has held or holds an abortion facility license or has been or is an affiliate of another licensed facility, the relationship, including the name and current or last address of the other facility, and the date such relationship commenced and, if applicable, the date it was terminated;

(vii) if the facility is operated by or proposed to be operated under a management contract, the names and addresses of any person and organization having an ownership interest of any percentage in the management company;

(viii) a notarized affidavit attesting that the applicant is capable of meeting the requirements of this chapter;

(ix) an organizational structure of the staffing for the abortion facility. The organizational structure shall include full disclosure in writing of the names and addresses of all owners and persons controlling any ownership interest in the abortion facility. In the case of corporations, holding companies, partnerships, and similar organizations, the names and addresses of officers, directors, and stockholders, both beneficial and of record, when holding any percent, shall be disclosed. In the case of a nonprofit corporation, the names and addresses of the officers and directors shall be disclosed;

(x) the name(s), address(es), and Texas physician license number(s) of the physician(s) (including the facility's designated medical consultant), and all advanced practice registered nurse(s) and physician assistant(s) who will provide services at the abortion facility;

(xi) the following data concerning the applicant, the applicant's affiliates, and the managers of the applicant:

(I) denial, suspension, probation, or revocation of an abortion facility license in any state, a license for any health care facility or a license for a home and community support services agency (agency) in any state or any other enforcement action, such as (but not limited to) court civil or criminal action in any state;

(II) denial, suspension, probation, or revocation of or other enforcement action against an abortion facility license in any state, a license for any health care facility in any state, or a license for an agency in any state which is or was proposed by the licensing agency and the status of the proposal;

(III) surrendering a license before expiration of the license or allowing a license to expire in lieu of the department proceeding with enforcement action;

(IV) federal or state (any state) criminal felony arrests or convictions;

(V) Medicare or Medicaid sanctions or penalties relating to the operation of a health care facility or agency;

(VI) operation of a health care facility or agency that has been decertified or terminated from participation in any state under Medicare or Medicaid; or

(VII) debarment, exclusion, or contract cancellation in any state from Medicare or Medicaid; and

(xii) for the two-year period preceding the application date, the following data concerning the applicant, the applicant's affiliates, and the managers of the applicant:

(I) federal or state (any state) criminal misdemeanor arrests or convictions;

(II) federal or state (any state) tax liens;

(III) unsatisfied final judgments;

(IV) eviction involving any property or space used as an abortion facility or health care facility in any state;

(V) injunctive orders from any court; or

(VI) unresolved final Medicare or Medicaid audit exceptions.

(3) Applicant copy. The applicant shall retain a copy of all documentation that is submitted to the department.

(4) Application processing. Upon the department's receipt of the application form, the required information described in paragraph (2)(C) of this subsection, and the initial license fee from an applicant, the department shall review the material to determine whether it is complete and correct.

(A) The time periods for reviewing the material shall be in accordance with §139.25 of this title (relating to Time Periods for Processing and Issuing a License).

(B) If an abortion facility receives a notice from the department that some or all of the information required under paragraph (2)(C) of this subsection is deficient, the facility shall submit the required information no later than six months from the date of the notice.

(i) A facility which fails to submit the required information within six months from the notice date is considered to have withdrawn its application for an initial license. The license fee shall not be refunded.

(ii) A facility which has withdrawn its application shall reapply for a license in accordance with this subsection, if it wishes to continue the application process. A new license fee is required.

(5) Withdrawal from the application process. If an applicant decides at any time not to continue the application process for an initial license, the application shall be withdrawn upon written request from the applicant.

(6) Issuance of an initial license.

(A) Time periods for processing. The time periods for processing an initial application shall be in accordance with §139.25 of this title.

(B) Effective period of an initial license. The initial license is valid for two years. The initial license expires on the last day of the month ending the licensure period.

(C) Pre-inspection conference. Once the department has determined that the application form, the information required to accompany the application form, and the initial license fee are complete and correct, the department shall schedule a pre-inspection conference with the applicant in order to inform the applicant or his or her designee of the standards for the operation of the abortion facility. The department, at its discretion, may waive the pre-inspection conference. Upon recommendation by the pre-inspection conference, the department shall issue an initial license to the facility.

(D) Pre-inspection recommendation. After the pre-inspection conference has been held, the department shall:

(i) issue an initial license to the owner of a facility, if the facility is found to be in compliance with the department's requirements for initial licensure; or

(ii) deny the application, if the facility has not complied with the department's requirements for issuing an initial license. The procedure for denial of a license shall be in accordance with §139.32 of this title (relating to License Denial, Suspension, Probation, or Revocation).

(7) A department representative shall inspect the abortion facility in accordance with §139.31 of this title (relating to On-Site Inspections and Complaint Investigations of a Licensed Abortion Facility) within 60 days after the issuance of an initial license. If the department determines that a facility is not in compliance with the provisions of the Act or this chapter after the initial on-site inspection, the department shall notify the facility. Notification shall be in accordance with §139.32 of this title.

(8) If for any reason, an applicant decides not to continue the application process, the applicant shall submit to the department a written request to withdraw its application. If an initial license has been issued, the applicant shall cease providing abortion services and return the initial license to the department with its written request to withdraw. The department shall acknowledge receipt of the request to withdraw. The license fee shall not be refunded.

(9) Continuing compliance by the abortion facility with the provisions of the Act and this chapter is required during the initial license period.

(d) Application procedures for renewal of a license.

(1) The department shall send notice of expiration of a license to the licensee at least 60 days before the expiration date of the license. If the licensee has not received notice of expiration from the department 45 days prior to the expiration date, it is the duty of the licensee to notify the department and request an application for a renewal license.

(2) The licensee shall submit the following items to the department by certified mail, marked confidential, and postmarked no later than 30 days prior to the expiration date of the license:

(A) a complete and accurate renewal application form;

(B) current updated documents containing all the information required in subsection (c)(2)(C) of this section; and

(C) the renewal license fee.

(3) A facility shall not misstate a material fact on any documents required to be submitted to the department or required to be maintained by the facility in accordance with the provisions of the Act and this chapter.

(4) A department surveyor shall inspect a licensed abortion facility in accordance with §139.31(b) of this title.

(5) If a licensee makes timely and sufficient application for renewal, the license shall not expire until the department issues the renewal license or until the department denies renewal of the license.

(A) The department shall issue a renewal license to a licensee who meets the minimum standards for a license in accordance with the provisions of the Act and this chapter.

(B) The department may propose to deny the issuance of a renewal license if:

(i) based on the inspection report, the department determines that the abortion facility does not meet or is in violation of any of the provisions of the Act or this chapter;

(ii) renewal is prohibited by the Education Code, §57.491, relating to defaults on guaranteed student loans;

(iii) a facility discloses any of the actions or offenses listed in subsection (c)(2)(C)(xi) and (xii) of this section; and

(iv) a facility fails to file abortion reports in accordance with §139.4 of this title (relating to Annual Reporting Requirements for All Abortions Performed) or fails to ensure that the physicians report is filed in accordance with §139.5 of this title (relating to Additional Reporting Requirements for Physicians).

(6) If a licensee makes a timely application for renewal of a license, and action to revoke, suspend, place on probation, or deny renewal of the license is pending, the license does not expire but does extend until the application for renewal is granted or denied after the opportunity for a formal hearing. A renewal license shall not be issued unless the department has determined the reason for the proposed action no longer exists.

(7) If a suspension of a license overlaps a renewal date, the suspended license holder shall comply with the renewal procedures in this subsection; however, the department may not renew the license until the department determines that the reason for suspension no longer exists.

(8) If the department revokes or does not renew a license, a person may apply for an initial license by complying with the requirements of the Act and this chapter at the time of reapplication. The department may refuse to issue a license, if the reason for revocation or non-renewal continues to exist.

(9) Upon revocation or non-renewal, a license holder shall return the original license to the department.

(10) The procedures for revocation, suspension, probation, or denial of a license shall be in accordance with §139.32 of this title.

(e) Failure to timely renew a license.

(1) If a licensee fails to timely renew a license in accordance with subsection (d) of this section, the department shall notify the licensee that the facility shall cease operation on the expiration date of the license.

(2) To continue providing services at the abortion facility after the expiration of the license, the owner shall apply for an initial license in accordance with subsection (c) of this section.

(f) Frequency of inspections. Inspections of the abortion facility shall be performed at a frequency prescribed by and in accordance with §139.31 of this title.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. ENFORCEMENT

25 TAC §§139.31 - 139.33

STATUTORY AUTHORITY

The repeals are authorized by Health and Safety Code, §245.009, concerning rules and minimum standards to protect and promote the public health and welfare by providing for the issuance, renewal, denial, suspension, and revocation of each license; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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25 TAC §§139.31 - 139.33

STATUTORY AUTHORITY

The new rules are authorized by Health and Safety Code, §245.009, concerning rules and minimum standards to protect and promote the public health and welfare by providing for the issuance, renewal, denial, suspension, and revocation of each license; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

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SUBCHAPTER D. MINIMUM STANDARDS FOR LICENSED ABORTION FACILITIES

25 TAC §§139.41 - 139.60

STATUTORY AUTHORITY

The repeals are authorized by Health and Safety Code, §245.009, concerning rules and minimum standards to protect and promote the public health and welfare by providing for the issuance, renewal, denial, suspension, and revocation of each license; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

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25 TAC §§139.41 - 139.60

STATUTORY AUTHORITY

The new rules are authorized by Health and Safety Code, §245.009, concerning rules and minimum standards to protect and promote the public health and welfare by providing for the issuance, renewal, denial, suspension, and revocation of each license; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Health and Safety Code, Chapter 1001. Review of the rules implements Government Code, §2001.039.

§139.46. Licensed Abortion Facility Staffing Requirements and Qualifications.

A licensed abortion facility shall have an adequate number of personnel qualified under this section available to provide direct patient care as needed by all patients; and administrative and nonclinical services needed to maintain the operation of the facility in accordance with the provisions of the Act and this chapter.

(1) Medical consultant. The medical consultant shall be a physician.

(2) Administrator.

(A) The administrator shall be at least 18 years of age, and shall meet at least one of the following qualifications:

(i) be a licensed health care professional;

(ii) have a baccalaureate degree, a postgraduate degree, or a professional degree and one year administrative experience in a health care or health-related field; or

(iii) have a minimum of two years of administrative experience in a health care or health-related facility.

(B) The administrator shall not have been employed in the last year as an administrator with another abortion facility or health-related facility at the time the facility was cited for violations of a licensing law or rule which resulted in enforcement action taken against the abortion facility or health-related facility. For purposes of this subparagraph only, the term "enforcement action" means license revocation, suspension, emergency suspension, probation, denial or injunctive action, but does not include administrative penalties or civil penalties. If the department prevails in one enforcement action (e.g., injunctive action) against the facility but also proceeds with another enforcement action (e.g., revocation) based on some or all of the same violations, but the department does not prevail in the second enforcement action (e.g., the facility prevails), the prohibition in this paragraph does not apply.

(C) The administrator shall not have been convicted of a felony or misdemeanor listed in §139.32 of this title (relating to License Denial, Suspension, Probation, or Revocation).

(3) Direct patient care staff.

(A) Medical staff. The medical staff shall include a physician and may include an advanced practice registered nurse or a physician assistant.

(B) Nursing staff. The nursing staff shall include a registered nurse(s) or a licensed vocational nurse(s).

(C) Education and information staff. Staff providing education and information services at the facility shall be a person(s) who is trained to provide information on surgical abortion procedures, medical abortions, alternatives to abortion, consent form, and family planning services, and meets at least one of the following additional qualifications:

(i) has one year experience in a health care facility;

(ii) has a baccalaureate degree; or

(iii) is a licensed professional mental health practitioner who provides therapeutic intervention.

(D) Laboratory staff. The laboratory staff shall include a person(s) who is trained to provide the laboratory services for the facility as determined by the medical consultant.

(4) Ancillary staff. Ancillary staff may include professional or nonprofessional staff who shall have training and experience to perform duties as prescribed by the administrator and the medical consultant as needed.

§139.47. Licensed Abortion Facility Administration.

(a) The administrator shall be responsible for implementing and supervising the administrative policies of the facility.

(b) The administrator shall:

(1) employ a qualified staff adequate in number to:

(A) provide the medical and clinical services;

(B) provide the nonclinical services; and

(C) maintain the abortion facility;

(2) ensure that employment of personnel is without regard to age, race, color, religion, national origin, sex, or disability;

(3) ensure that all medical and clinical personnel hold current Texas licenses to practice their respective disciplines/professions, if applicable;

(4) develop and make available to all staff and the department, a policy and procedure manual including protocols and description of the roles and responsibilities of all personnel;

(5) ensure that assignment of duties and functions to each employee are commensurate with his/her licensure, certification, and experience and competence;

(6) ensure that staff receive training, education, and orientation to their specific job description, facility personnel policies, philosophy, and emergency procedures in accordance with this section;

(7) schedule employee evaluations;

(8) maintain employee and patient records;

(9) ensure the accuracy of public education information materials and activities in relation to abortion, birth control, and sexually-transmitted diseases. The department shall be the primary resource for human immunodeficiency virus (HIV) education, prevention, risk reduction materials, policies, and information. Educational materials may be obtained by writing or calling the Department of State Health Services Warehouse, Literature and Forms, 1100 West 49th Street Austin, Texas 78756, (512) 458-7761;

(10) implement an effective budgeting, accounting, and auditing system for receipt of state or federal funds;

(11) ensure that all advertisements for the facility include the unique identifying license number assigned by the department in accordance with §139.7 of this title (relating to Unique Identifying Number; Disclosure in Advertisement);

(12) ensure that a woman on whom the abortion is to be performed, at the time of initial on-site consultation, receives the information required to be disclosed under §139.50 of this title (relating to Disclosure Requirements); and

(13) ensure that the reporting requirements of §139.4 of this title (relating to Annual Reporting Requirements for All Abortions Performed) are performed.

(c) A licensed abortion facility shall report violations of practice acts and conditions of license for its licensed health care professional(s) to the appropriate licensing board. If the patient is unsatisfied with the facility's findings, the facility shall provide the complainant with the name, address, and telephone number of the appropriate licensing board. The facility shall document the review and action taken by the facility.

§139.48. Physical and Environmental Requirements.

The physical and environmental requirements for a licensed abortion facility are as follows.

(1) A facility shall:

(A) have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients and staff at all times;

(B) equip each procedure room so that procedures can be performed in a manner that assures the physical safety of all individuals in the area;

(C) have a separate recovery room if moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia are administered at the facility;

(D) have a written protocol for emergency evacuation for fire and other disasters tailored to the facility's geographic location. Each staff member employed by or under contract with the facility shall be able to demonstrate their role or responsibility to implement the facility's emergency evacuation protocol required by this subparagraph;

(E) store hazardous cleaning solutions and compounds in a secure manner and label substances;

(F) have the capacity to provide patients with liquids. The facility may provide commercially packaged food to patients in individual servings. If other food is provided by the facility, it shall be subject to the requirements of §§229.161 - 229.171 of this title (relating to Texas Food Establishments);

(G) provide clean hand washing facilities for patients and staff including running water, and soap;

(H) have two functioning sinks and a functioning toilet; and

(I) have equipment available to sterilize instruments, equipment, and supplies in accordance with §139.49(d) of this title (relating to Infection Control Standards) before use in the facility.

(2) The equipment for vacuum aspiration shall be electrically safe and designed to prevent reverse pump action in facilities that provide vacuum aspiration.

(3) Projects involving alterations of and additions to existing buildings shall be programmed and phased so that on-site construction shall minimize disruptions of existing functions. Access, exit ways, and fire protection shall be maintained so that the safety of the occupants shall not be jeopardized during construction.

§139.49. Infection Control Standards.

(a) Written policies. A licensed abortion facility shall develop, implement, and enforce infection control policies and procedures to minimize the transmission of post-procedure infections. These policies shall include, but not be limited to, the prevention of the transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), Mycobacterium tuberculosis (TB), and Streptococcus species (S. spp.); educational course requirements; cleaning and laundry requirements; and decontamination, disinfection, sterilization, and storage of sterile supplies.

(b) Prevention and control of the transmission of HIV, HBV, HCV, TB, and S. spp.

(1) Universal/standard precautions.

(A) An abortion facility shall ensure that all staff comply with universal/standard precautions as defined in this paragraph.

(i) Universal/standard precautions includes procedures for disinfection and sterilization of reusable medical devices and the appropriate use of infection control, including hand washing, the use of protective barriers, and the use and disposal of needles and other sharp instruments.

(ii) Universal/standard precautions synthesize the major points of universal precautions with the points of body substance precautions and apply them to all patients receiving care in facilities, regardless of their diagnosis or presumed infection status.

(I) Universal/standard precautions apply to:

(-a-) blood;

(-b-) body fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood;

(-c-) nonintact skin; and

(-d-) mucous membranes.

(II) Universal/standard precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in facilities.

(B) A licensed abortion facility shall establish procedures for monitoring compliance with universal/standard precautions described in subparagraph (A) of this paragraph.

(2) Health care workers infected with the HIV or HBV. A licensed abortion facility shall adopt, implement, and enforce a written policy to ensure compliance of the facility and all of the health care workers within the facility with the Health and Safety Code, Chapter 85, Subchapter I, concerning the prevention of the transmission of HIV and HBV by infected health care workers.

(3) Educational course work and training. A licensed abortion facility shall require its health care workers to complete educational course work or training in infection control and barrier precautions, including basic concepts of disease transmission, scientifically accepted principles and practices for infection control and engineering and work practice controls. To fulfill the requirements of this paragraph, course work and training may include formal education courses or in-house training or workshops provided by the facility. The course work and training shall include, but not be limited to:

(A) HIV infection prevention; and

(B) HBV, HCV, TB, and S. spp. infection prevention based on universal/standard precautions as defined in paragraph (1) of this subsection;

(C) bidirectional aspect of disease transmission; and

(D) epidemic control.

(c) Cleaning and laundry policies and procedures.

(1) A licensed abortion facility shall develop, implement, and enforce written policies and procedures on cleaning the procedure room(s).

(2) A licensed abortion facility shall develop, implement, and enforce written policies and procedures for the handling, processing, storing, and transporting of clean and dirty laundry.

(3) A licensed abortion facility may provide cleaning and laundry services directly or by contract in accordance with Occupational Safety and Health Administration's Standards, 29 Code of Federal Regulations, Subpart Z. Bloodborne Pathogens.

(d) Policies and procedures for decontamination, disinfection, sterilization, and storage of sterile supplies. A licensed abortion facility shall have written policies covering its procedures for the decontamination and sterilization activities performed. Policies shall include, but not be limited to, the receiving, cleaning, decontaminating, disinfecting, preparing and sterilization of critical items (reusable items), as well as those for the assembly, wrapping, storage, distribution, and the monitoring and control of sterile items and equipment.

(1) Supervision. The decontamination, disinfection, and sterilization of all supplies and equipment shall be under the supervision of a person qualified by education, training, or experience.

(2) Quantity of sterile surgical instruments. The facility shall ensure that surgical instruments are sufficient in number to permit sterilization of the instrument(s) used for each procedure and adequate to perform conventional cervical dilatation and curettage if this procedure is available at the facility.

(3) Inspection of surgical instruments.

(A) All instruments shall undergo inspection before being packaged for reuse or storage. Routine inspection of instruments shall be made to assure clean locks, crevices, and serrations.

(B) Inspection procedures shall be thorough and include visual and manual inspection for condition and function.

(i) Cutting edges shall be checked for sharpness; tips shall be properly aligned, and box locks shall be clean and free from buildup of soap, detergent, dried blood, or tissue.

(ii) There shall be no evident cracks or fissures in the box locks, and the hinges shall work freely.

(iii) Ratchets shall hold and be routinely tested.

(iv) There shall be no corrosion or pitting of the finish.

(C) Instruments needing maintenance shall be taken out of service and repaired by someone qualified to repair surgical instruments.

(D) To protect the instrument and its protective finish, impact markers or electric engravers shall not be used for instrument identification. Instrument identification shall be accomplished by the instrument manufacturer, employing methods which shall not damage the instrument or its protective finish.

(4) Items to be disinfected and sterilized.

(A) Critical items.

(i) Critical items include all surgical instruments and objects that are introduced directly into the bloodstream or into other normally sterile areas of the body and shall be sterilized in accordance with this subsection.

(ii) All items that come in contact with the sterile field during the operative procedure shall be sterile.

(B) Semicritical items.

(i) Semicritical items include items that come in contact with nonintact skin or mucous membranes. Semicritical items shall be free of microorganisms, except bacterial spores. Semicritical items may include respiratory therapy equipment, anesthesia equipment, bronchoscopes, and thermometers.

(ii) High-level disinfection shall be used for semicritical items.

(C) Noncritical items.

(i) Noncritical items include items that come in contact with intact skin.

(ii) Intermediate-level or low-level disinfection shall be used for noncritical items.

(5) Equipment and sterilization procedures. Effective sterilization of instruments depends on performing correct methods of cleaning, packaging, arrangement of items in the sterilizer, and storage. The following procedures shall be included in the written policies as required in this subsection to provide effective sterilization measures.

(A) Equipment. A licensed abortion facility shall provide sterilization equipment adequate to meet the requirements of this paragraph for sterilization of critical items. Equipment shall be maintained and operated to perform, with accuracy, the sterilization of critical items.

(B) Environmental requirements. Where cleaning, preparation, and sterilization functions are performed in the same room or unit, the physical facilities, equipment, and the written policies and procedures for their use shall be such as to effectively separate soiled or contaminated supplies and equipment from the clean or sterilized supplies and equipment.

(i) A facility shall have a sink for hand washing. This sink shall not be used for cleaning instruments or disposal of liquid waste.

(ii) A facility shall have a separate sink for cleaning instruments and disposal of liquid waste. Hand washing shall only be performed at this sink after it has been disinfected.

(C) Preparation for sterilization.

(i) All items to be sterilized shall be prepared to reduce the bioburden. All items shall be thoroughly cleaned, decontaminated and prepared in a clean, controlled environment. Cleaning is the removal of all adherent visible soil from the surfaces, crevices, joints, and lumens of instruments. Decontamination is the physical/chemical process that renders an inanimate object safe for further handling.

(ii) One of the following methods of cleaning and decontamination shall be used as appropriate.

(I) Manual cleaning. Manual cleaning of instruments at the sink is permitted.

(II) Ultrasonic cleaning. Ultrasonic cleaning of instruments cleans by cavitation and reduces the need for hand scrubbing. When grossly soiled items are placed in the ultrasonic cleaner the water shall be changed more than once a shift. If using this method for cleaning, chambers shall be covered to prevent potential hazards to personnel from aerosolization of the contents.

(III) Washer-sterilizers. Washer-sterilizers clean by using rotating spray arms to create water jets that clean by impingement and appropriate soap and disinfectant. These machines shall reach a temperature of 140 degrees Celsius (285 degrees Fahrenheit).

(IV) Washer-decontaminator machines. Washer-decontaminator machines clean by numerous water jets and a high pH of detergent even if instruments are grossly soiled. The thorough cleaning is followed by a neutralizing rinse to quickly restore the pH to neutral.

(iii) All articles to be sterilized shall be arranged so all surfaces shall be directly exposed to the sterilizing agent for the prescribed time and temperature.

(D) Packaging.

(i) All wrapped articles to be sterilized shall be packaged in materials recommended for the specific type of sterilizer and material to be sterilized, and to provide an effective barrier to microorganisms. Acceptable packaging includes peel pouches, perforated metal trays, or rigid trays. Muslin packs shall be limited in size to 12 inches by 12 inches by 20 inches with a maximum weight of 12 pounds. Wrapped instrument trays shall not exceed 17 pounds.

(ii) All items shall be labeled for each sterilizer load as to the date and time of sterilization, the sterilizing load number, and the autoclave.

(E) External chemical indicators.

(i) External chemical indicators, also known as sterilization process indicators, shall be used on each package to be sterilized, including items being flash sterilized to indicate that items have been exposed to the sterilization process.

(ii) The indicator results shall be interpreted according to the manufacturer's written instructions and indicator reaction specifications.

(F) Biological indicators.

(i) The efficacy of the sterilizing process shall be monitored with reliable biological indicators appropriate for the type of sterilizer used (e.g., Bacillus stearothermophilus for steam sterilizers).

(ii) Biological indicators shall be included in at least one run each day of use for steam sterilizers.

(iii) A log shall be maintained with the load identification, biological indicator results, and identification of the contents of the load.

(iv) If a test is positive, the sterilizer shall immediately be taken out of service. A malfunctioning sterilizer shall not be put back into use until it has been serviced and successfully tested according to the manufacturer's recommendations.

(v) All available items shall be recalled and reprocessed if a sterilizer malfunction is found. A list of all items which were used after the last negative biological indicator test shall be submitted to the administrator.

(G) Sterilizers.

(i) Steam sterilizers (saturated steam under pressure) shall be utilized for sterilization of heat and moisture stable items. Steam sterilizers shall be used according to manufacturer's written instructions.

(ii) Other sterilizers shall be used in accordance with the manufacturer's instructions.

(H) Maintenance of sterility.

(i) Items that are properly packaged and sterilized shall remain sterile indefinitely unless the package becomes wet or torn, has a broken seal, is damaged in some way, or is suspected of being compromised.

(ii) Medication or materials within a package that deteriorate with the passage of time shall be dated according to the manufacturer's recommendations.

(iii) All packages shall be inspected before use. If a package is torn, wet, discolored, has a broken seal, or is damaged, the item may not be used. The item shall be returned to sterile processing for reprocessing.

(I) Commercially packaged items. Commercially packaged items are considered sterile according to the manufacturer's instructions.

(J) Storage of sterilized items. The loss of sterility is event related, not time related. The facility shall ensure proper storage and handling of items in a manner that does not compromise the packaging of the product.

(i) Sterilized items shall be transported so as to maintain cleanliness and sterility and to prevent physical damage.

(ii) Sterilized items shall be stored in well-ventilated, limited access areas with controlled temperature and humidity.

(iii) Sterilized items shall be positioned so that the packaging is not crushed, bent, compressed, or punctured so that their sterility is not compromised.

(iv) Storage of supplies shall be in areas that are designated for storage.

(K) Disinfection.

(i) The manufacturer's written instructions for the use of disinfectants shall be followed.

(ii) An expiration date, determined according to manufacturer's written recommendations, shall be marked on the container of disinfection solution currently in use.

(iii) Disinfectant solutions shall be kept covered and used in well-ventilated areas.

(L) Performance records.

(i) Performance records for all sterilizers shall be maintained for each cycle. These records shall be retained and available for review for a minimum of two years.

(ii) Each sterilizer shall be monitored during operation for pressure, temperature, and time at desired temperature and pressure. A record shall be maintained either manually or machine generated and shall include:

(I) the sterilizer identification;

(II) sterilization date and time;

(III) load number;

(IV) duration and temperature of exposure phase (if not provided on sterilizer recording charts);

(V) identification of operator(s);

(VI) results of biological tests and dates performed; and

(VII) time-temperature recording charts from each sterilizer (if not provided on sterilizer recording charts).

(M) Preventive maintenance. Preventive maintenance of all sterilizers shall be performed according to individual policy on a scheduled basis by qualified personnel, using the sterilizer manufacturer's service manual as a reference. A preventive maintenance record shall be maintained for each sterilizer. These records shall be retained at least two years and shall be available for review to the facility within two hours of request by the department.

§139.51. Patient Rights at the Facility.

A licensed abortion facility shall ensure that all women on whom the abortion is to be performed:

(1) be allowed to make her own choice and self-determination;

(2) are ensured the right to personal privacy and confidentiality of her choices and decisions;

(3) are ensured the right to voluntary and informed consent as defined in Health and Safety Code, §171.012, without paying a fee for the informational materials;

(4) are ensured individual counseling concerning private medical information and to be given a private opportunity to ask questions;

(5) be allowed to view their medical record, including the sonogram, if one has been performed, at any time as provided by law;

(6) have access to care and treatment consistent with available resources and generally accepted standards regardless of race, color, national origin, age, sex, religion or disability;

(7) are allowed to ask additional questions after giving consent and to withdraw consent while still medically safe to do so;

(8) are provided freedom from abuse, neglect, or exploitation as those terms are defined in §1.204 of this title (relating to Abuse, Neglect, and Exploitation Defined); and

(9) be allowed to review the department's informational materials as described in Health and Safety Code, §171.014 and §171.015.

§139.53. Medical and Clinical Services.

(a) Surgical abortion.

(1) The medical consultant shall be responsible for implementing and supervising the medical and clinical policies of the facility.

(2) All medical and clinical services of the facility, with the exception of the abortion procedure, shall be provided under the direction of a physician or registered nurse who assumes responsibility for the clinical employees' performance in the facility.

(3) A licensed abortion facility shall ensure that a surgical consent form is signed by the patient prior to the procedure being started, that the patient is informed of the risks and the benefits of the procedure, and that the patient recognizes the alternatives to abortion. Informed consent shall be in accordance with rules adopted by the Texas Medical Disclosure Panel under §601.2 of this title (relating to Procedures Requiring Full Disclosure of Specific Risks and Hazards--List A), §601.4 of this title (relating to Disclosure and Consent Form), and Health and Safety Code, §171.011 (relating to Informed Consent Required), and §171.012 (relating to Voluntary Informed Consent).

(4) A licensed abortion facility shall ensure that the attending physician, advanced practice registered nurse, or physician assistant has obtained and documented a preoperative history, physical exam, and laboratory studies, including verification of pregnancy.

(5) A licensed abortion facility shall ensure that:

(A) the attending physician examines each patient immediately prior to surgery to evaluate the risk to the procedure; and

(B) the person administering the anesthetic agent(s) examines the patient immediately prior to surgery to evaluate the risk of anesthesia.

(6) The administration of anesthesia shall be in accordance with §139.59 of this title (relating to Anesthesia Services).

(7) An abortion shall be performed only by a physician.

(8) A physician, advanced practice registered nurse, physician assistant, registered nurse, or licensed vocational nurse shall be in the facility whenever there is a patient in the procedure room or recovery room. While a patient is in the procedure room or recovery room she shall not be left unattended.

(9) The recovery room(s) at the facility shall be supervised by a physician, advanced practice registered nurse, physician assistant, or registered nurse. This supervisor shall be available for recovery room staff within a recommended 10 minutes with a maximum required 15 minutes while any patient is in the recovery room.

(10) A physician shall be available for the facility while any patient is in the recovery room within a recommended 10 minutes and a maximum required 15 minutes.

(11) The facility shall ensure that a patient is fully reactive and her vital signs are stable before discharging the patient from the facility upon written order by the attending physician.

(12) All fetal tissue shall be examined grossly at the time of the procedure. In the absence of visible fetal parts or placenta, the tissue may be examined by magnification for the detection of villi. If this examination is inconclusive, the tissue shall be sent to a pathology lab. The results of the tissue examination shall be recorded in the patient's clinical record.

(13) A facility shall meet the requirements set forth by the department in §§1.131 - 1.137 of this title (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).

(b) Medical abortion.

(1) The medical consultant shall be responsible for implementing and supervising the medical and clinical policies of the facility.

(2) All medical and clinical services of the facility, with the exception of the abortion procedure, shall be provided under the direction of a physician or registered nurse who assumes responsibility for the clinical employees' performance in the facility.

(3) A licensed abortion facility shall ensure:

(A) the physician(s) providing medical abortion is able to accurately date a pregnancy;

(B) the physician(s) is able to determine that the pregnancy is not an ectopic gestation;

(C) the physician(s) is able to provide surgical intervention or provide for the patient to receive a surgical abortion if necessary; and

(D) patients have access to medical facilities equipped to provide blood transfusion and patient resuscitation, if necessary.

(4) A licensed abortion facility shall ensure follow-up examination and services are provided to patients requesting medical abortion.

(5) A licensed abortion facility shall ensure that the attending physician, advanced practice registered nurse, or physician assistant has obtained and documented a pre-procedure history, physical exam, and laboratory studies, including verification of pregnancy.

(6) A licensed abortion facility shall ensure:

(A) written consent is obtained from the patient prior to the commencement of the abortion procedure;

(B) the patient is informed of the risks and benefits of the procedure;

(C) the patient is informed of the possibility that a surgical abortion may be required;

(D) the patient is informed of the alternatives to abortion; and

(E) informed consent is in accordance with rules adopted by the Texas Medical Disclosure Panel under §601.2 of this title, §601.4 of this title, and Health and Safety Code, §171.011 and §171.012.

(7) A licensed abortion facility shall provide the patient with written discharge instructions including a direct referral to a physician who shall accept the patient for surgical abortion.

§139.54. Health Care Services.

(a) Definition. For the purposes of this section, the term "health care professional" includes:

(1) a physician;

(2) an advanced practice registered nurse;

(3) a physician assistant;

(4) a registered nurse;

(5) a licensed vocational nurse; or

(6) a licensed mental health practitioner.

(b) Licensed health care professionals.

(1) A licensed abortion facility shall ensure that its licensed health care professionals practice within the scope of their practice and within the constraints of applicable state laws and regulations governing their practice and follow the facility's written policies and procedures.

(2) A licensed abortion facility may allow physicians to train nonlicensed personnel, age 18 years or above, to extract blood for laboratory testing and to administer intravenous fluids.

(c) Student health care professionals. If the facility has a contract or agreement with an accredited school of health care to use their facility for a portion of the students' clinical experience, those students may provide care under the following conditions.

(1) Students may be used in facilities, provided the instructor gives class supervision and assumes responsibility for all student activities occurring within the facility. If the student is licensed, such as a licensed vocational nurse attending a registered nurse program for licensure as a registered nurse, the facility shall ensure that the administration of any medication(s) is within the student's licensed scope of practice.

(2) All instruction shall be provided by the school's instructor or his or her designee.

(3) A student may administer medications only if:

(A) on assignment as a student of their school of health care; and

(B) the instructor is on the premises and directly supervises the administration of medication by an unlicensed student, and the administration of such medication is within the instructor's licensed scope of practice.

(4) Students shall not be used to fulfill the requirement for administration of medications by licensed personnel.

(5) Students shall not be considered when determining staffing needs required by the facility.

§139.57. Discharge and Follow-up Referrals.

(a) A licensed abortion facility shall develop and implement written discharge instructions which shall include:

(1) a list of complications (developed by the facility in conjunction with a physician who practices in the facility) that warrant the patient contacting the facility, which shall include, but not be limited to:

(A) pain;

(B) fever; and

(C) bleeding;

(2) a statement of the facility's plan to respond to the patient in the event the patient experiences any of the complications listed in the discharge instructions to include:

(A) the mechanism by which the patient may contact the facility on a 24-hour basis by telephone answering machine or service, or by direct contact with an individual;

(B) the facility's requirement that every reasonable effort be made and documented to respond to the patient within 30 minutes of the patient's call;

(C) assurance that the responding individual shall be a physician, advanced practice registered nurse, physician assistant, registered nurse, or licensed vocational nurse; and

(D) information that the patient may also contact the emergency medical service or present for care at the emergency room of a hospital in addition to contacting the facility; and

(3) information concerning the need for a post-abortion examination.

(b) A facility shall provide a patient with a copy of the written discharge instructions described in subsection (a) of this section.

(c) The facility shall develop and implement written policies and procedures for:

(1) examination or referral of all patients who report complications, as identified in the list required by subsection (a)(1) of this

section, to the facility after an abortion procedure. The written policy and procedure shall require:

(A) the facility to maintain a written system of documentation of patients who report post-abortion complications within 14 days of the procedure date;

(B) documentation of the facility's action following a patient's reporting of post-abortion complications to be placed in the patient's record; and

(C) the patients' records to be maintained for adults for seven years and for minors five years past the age the patient reaches majority; and

(2) periodic review of the record keeping system for post-abortion complications to identify problems and potential problems and to make changes in order to resolve the problems.

§139.59. Anesthesia Services.

(a) Anesthesia services, when provided in the abortion facility, shall be limited to those that are approved by the governing body, which may include the following:

(1) Topical anesthesia--An anesthetic agent applied directly or by spray to the skin or mucous membranes, intended to produce transient and reversible loss of sensation to the circumscribed area.

(2) Local anesthesia--Administration of an agent that produces a transient and reversible loss of sensation to a circumscribed portion of the body.

(3) Regional anesthesia--Anesthetic injected around a single nerve, a network of nerves, or vein that serves the area involved in a surgical procedure to block pain.

(4) Minimal sedation (anxiolysis)--A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

(5) Moderate sedation/analgesia ("conscious sedation")--A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. (Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.)

(6) Deep sedation/analgesia--A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. (Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.)

(7) General anesthesia--A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

(b) An anesthesia department shall be required if moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia are administered at the facility and shall be under the medical direction of a physician approved by the governing body upon the recommendation of the abortion facility medical staff.

(c) The medical staff shall develop written policies and practice guidelines for the anesthesia service, which shall be approved, implemented and enforced by the governing body. The policies and guidelines shall include consideration of the applicable practice standards and guidelines of the American Society of Anesthesiologists, the American Association of Nurse Anesthetists, and the licensing rules and standards applicable to those categories of licensed professionals qualified to administer anesthesia.

(d) Only personnel who have been approved by the facility to provide anesthesia services shall administer anesthesia. All approvals or delegations of anesthesia services as authorized by law shall be documented and include the training, experience, and qualifications of the person who provided the service. A qualified registered nurse (RN) who is not a certified registered nurse anesthetist (CRNA), in accordance with the orders of the operating surgeon, anesthesiologist, or CRNA may administer topical anesthesia, local anesthesia, minimal sedation and moderate sedation, in accordance with all applicable rules, polices, directives and guidelines issued by the Texas Board of Nursing. When an RN who is not a CRNA administers sedation, as permitted in this paragraph, the facility shall:

(1) verify that the registered nurse has the requisite training, education, and experience;

(2) maintain documentation to support that the registered nurse has demonstrated competency in the administration of sedation;

(3) with input from the facility's qualified anesthesia providers, develop, implement and enforce detailed, written policies and procedures to guide the registered nurse; and

(4) ensure that, when administering moderate sedation during a procedure, the registered nurse has no other duties except to monitor the patient.

(e) Anesthesia shall not be administered unless the operating surgeon has evaluated the patient immediately prior to the procedure to assess the risk of the anesthesia and of the procedure to be performed.

(f) The CRNA, the anesthesiologist, or the operating surgeon shall be available until all of his or her patients operated on that day have been discharged from the recovery room.

(g) Patients who have received anesthesia shall be evaluated for proper anesthesia recovery by the operating surgeon or the person administering the anesthesia prior to discharge from the recovery room using criteria approved by the medical staff.

(h) Patients who remain in the facility for extended observation following discharge from the recovery room shall be evaluated immediately prior to leaving the facility by a physician, the person administering the anesthesia, or a registered nurse acting in accordance with physician's orders and written policies, procedures and criteria developed by the medical staff.

(i) A physician shall be on call and able to respond physically or by telephone within 30 minutes until all patients have been discharged from the abortion facility.

(j) Emergency equipment and supplies appropriate for the type of anesthesia services provided shall be maintained and accessible to staff at all times.

(1) Functioning equipment and supplies which are required for all facilities include:

(A) suctioning equipment, including a source of suction and suction catheters in appropriate sizes for the population being served;

(B) source of compressed oxygen;

(C) basic airway management equipment, including oral and nasal airways, face masks, and self-inflating breathing bag valve set;

(D) blood pressure monitoring equipment; and

(E) emergency medications specified by the medical staff and appropriate to the type of surgical procedures and anesthesia services provided by the facility.

(2) In addition to the equipment and supplies required under paragraph (1) of this subsection, facilities which provide moderate sedation/analgesia, deep sedation/analgesia, regional analgesia and/or general anesthesia shall provide the following:

(A) intravenous equipment, including catheters, tubing, fluids, dressing supplies, and appropriately sized needles and syringes;

(B) advanced airway management equipment, including laryngoscopes and an assortment of blades, endotracheal tubes and stylets in appropriate sizes for the population being served;

(C) a mechanism for monitoring blood oxygenation, such as pulse oximetry;

(D) electrocardiographic monitoring equipment;

(E) cardiac defibrillator; and

(F) pharmacologic antagonists as specified by the medical staff and appropriate to the type of anesthesia services provided.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 7. CORPORATE AND FINANCIAL REGULATION

SUBCHAPTER P. LICENSING AND EXAMINATION OF THIRD PARTY ADMINISTRATORS

28 TAC §§7.1601 - 7.1617

The Commissioner of Insurance (Commissioner or Department) adopts the repeal of Subchapter P, §§7.1601 - 7.1617, concerning licensing and examination of third party administrators. The repeal is adopted without changes to the proposed text published in the December 5, 2008, issue of the *Texas Register* (33 TexReg 9903).

REASONED JUSTIFICATION. This repeal is necessary because the Department is adopting a new Subchapter P, §§7.1601 - 7.1618, that implements House Bill (HB) 472, enacted by the 80th Legislature, Regular Session, effective September 1, 2007, which amends the Insurance Code Chapter 4151. The Insurance Code Chapter 4151 regulates administrators, entities which are delegated authority for claims adjustment and settlement and premium collection. HB 472 enacts significant changes to the Insurance Code Chapter 4151, including requiring persons providing administrative services in connection with workers' compensation benefits in this state to be regulated by the Department under the Insurance Code Chapter 4151 and increasing the reporting, contracting, and oversight requirements for all administrators regulated by the Department. As a result, the new subchapter is necessary to implement these new statutory requirements. Specifically, the new subchapter is needed to (i) eliminate outdated and inapplicable requirements; (ii) define the scope of the new subchapter and update the terms to be used in the new subchapter; (iii) streamline the application process for a certificate of authority under the Insurance Code Chapter 4151; (iv) prescribe new fingerprinting requirements; (v) clarify notification requirements related to changes in the ownership or control of an administrator or applicant and in the facts and circumstances affecting the issuance of a certificate of authority under the Insurance Code Chapter 4151; (vi) prescribe requirements relating to fidelity bonds and annual reporting requirements; (vii) clarify the format and content of financial statements required under the Education Code for certain administrators; (viii) prescribe requirements for the review and on-site audit of certain administrators; (ix) prescribe requirements related to fiduciary bank accounts; (x) clarify the content of written agreements required under the Insurance Code Chapter 4151; (xi) specify certain prohibited transactions; (xii) prescribe requirements related to the transfer and maintenance of books and records; (xiii) provide clarification of hazardous or injurious operating conditions; and (xiv) establish new application, annual report, and examination fees. The adopted new subchapter is also published in this edition of the *Texas Register.*

HOW THE SECTIONS WILL FUNCTION. The adoption of the repeal will result in the elimination of outdated and inapplicable requirements.

SUMMARY OF COMMENTS AND AGENCY RESPONSE. The Department did not receive any comments on the proposed repeal.

STATUTORY AUTHORITY. The repeal of §§7.1601 - 7.1617 is adopted pursuant to the Insurance Code §4151.006 and §36.001. The Insurance Code §4151.006 provides that the Commissioner may adopt, in the manner prescribed by Chapter 36, Subchapter A, rules that are fair, reasonable, and appropriate to augment and implement Chapter 4151, including rules establishing financial standards, reporting requirements, and required contract provisions. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER P. ADMINISTRATORS

28 TAC §§7.1601 - 7.1618

The Commissioner of Insurance (Commissioner or Department) adopts new Subchapter P, §§7.1601 - 7.1618, concerning administrators. Section 7.1613 and §7.1616 are adopted with changes to the proposed text published in the December 5, 2008, issue of the *Texas Register* (33 TexReg 9904). Sections 7.1601 - 7.1612, 7.1614, 7.1615, 7.1617, and 7.1618 are adopted without changes.

REASONED JUSTIFICATION. The adopted new sections are necessary to implement House Bill (HB) 472, enacted by the 80th Legislature, Regular Session, effective September 1, 2007, which amends the Insurance Code Chapter 4151. Chapter 4151 regulates administrators as that term is defined in §4151.001 of the Insurance Code and §7.1602(1) of these rules. The adopted rules are necessary to implement the licensing, reporting, oversight, and contracting requirements of the Insurance Code Chapter 4151.

The Department is simultaneously adopting the repeal of existing §7.1601 (relating to Definitions); §7.1602 (relating to Forms Relating to Regulation and Exemption of Administrators under the Insurance Code, Article 21.07-6); §7.1603 (relating to Application for Certificate of Authority); §7.1604 (relating to Application Denial, Suspension, Cancellation, or Revocation); §7.1605 (relating to Application Procedures); §7.1606 (relating to Exemption from Department Licensing and Regulation for Certain Administrators); §7.1607 (relating to Identification and Reporting Requirements for Certain Insurers and Health Maintenance Organizations); §7.1608 (relating to Fees); §7.1609 (relating to Prohibited Transactions); §7.1610 (relating to On-Site Visits); §7.1611 (relating to Cease and Desist Orders); §7.1612 (relating to Supplemental Information/Annual Report); §7.1613 (relating to Fidelity Bond); §7.1614 (relating to Maintenance Tax); §7.1615 (relating to Severability); §7.1616 (relating to Limited Certificate of Authority for Non-Texas-Licensed Third Party Administrators for Multi-Jurisdictional Impaired Insurance Companies Estate Administration); and §7.1617 (relating to School District Group Health Coverage Contracts). The adopted repeal of these sections is also published in this issue of the *Texas Register.* This adoption includes new sections to replace the repealed sections.

The Department held a stakeholder's meeting on October 18, 2007, to discuss implementation of HB 472 with interested parties and invited public input concerning implementation, including comments and questions pertaining to the adoption of new rules the Department anticipated proposing to implement HB 472. The Department posted a first informal working draft of the proposed new rules on the Department's internet website from November 26 to December 14, 2007, and invited public input. The Department received several written comments regarding the informal working draft of the proposed new rules. The Department made several revisions to the first informal working draft in response to the public input received and posted a second informal working draft of the proposed new rules on the Department's website from October 21 to October 27, 2008, and again invited public comment. The Department received several written comments regarding the second informal working draft of the proposed new rules. The Department also held a series of meetings with various interested parties that expressed a desire to meet with the Department to provide input on the proposed new rules. As a result of the written comments provided by industry representatives on the two informal working drafts of the proposed rules and the series of discussions with the interested parties, the Department modified several sections of the informal working draft of the proposed new rules, including revisions to (i) narrow the scope and matters to be considered by insurers during required semi-annual reviews and on-site biennial audits of administrators; (ii) reduce the number of required semi-annual reviews and biennial on-site audits by providing that reviews and audits of administrator subcontractors are not required if certain conditions are met; (iii) reduce the number of required semi-annual reviews and biennial on-site audits by increasing the threshold that the requirement to perform the required reviews and audits is triggered based upon a minimum threshold of, in the aggregate, each administrator that administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants or policyholders; (iv) reduce the number of required operational reviews of administrators by providing that an on-site audit may count as one of the required annual operational reviews during the same fiscal year that the on-site audit is conducted; (v) reduce the number of administrators that are required to provide audited financial statements to the Department by clarifying that this requirement is triggered only for an administrator that receives at least $10 million in compensation for providing administrative services in Texas during the preceding calendar year; and (vi) increase the length of time that an administrator has to notify the Department in writing if an administrator's fidelity bond is cancelled and not replaced with new coverage effective concurrently upon the date of the cancellation or termination. The new rules were formally published in the December 5, 2008, issue of the *Texas Register* (33 TexReg 9904). A public hearing on the rule proposal was held on January 21, 2009. In response to written comments on the published proposal and comments made at the hearing, the Department has changed some of the proposed language in the text of the rule as adopted. The changes, however, do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

As a result of comments, §7.1613(d)(1) as adopted is changed to require a written agreement entered into under §7.1613 to include a requirement that the administrator must comply with all statutory, contractual, and regulatory requirements related to a function assumed or carried out by the administrator and related to a plan for which the administrator performs or offers to perform administrative services. This change is in response to a commenter who objected to proposed §7.1613(d)(1). According to the commenter, proposed §7.1613(d)(1) requires written agreements to cite to compliance with specific Texas state laws, which would be onerous and impracticable in agreements that address services provided in numerous jurisdictions on a na-

tional basis. The commenter stated that agreements between insurers and administrators often contain general provisions that the administrator shall comply with all applicable laws and regulations. The commenter recommended that the requirement that the written agreements contain references to several specific Texas statutes be deleted, or if not deleted, then, the deadline for implementation of the written agreement provisions be extended until at least June 1, 2010. Though the Department disagrees with the recommended changes, the Department believes that its revisions to §7.1613(d)(1) in the adoption address the commenter's concerns by giving insurers and administrators more flexibility in meeting the contract requirement in §7.1613(d)(1). Section 7.1613(d)(1) as adopted does not require written agreements to contain specific references to specific Texas statutes or regulations.

Also, as a result of comments, §7.1616(b) is changed as adopted to state that "Other facts and circumstances not specified in §7.1616(a), as determined by the commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state may also indicate that an applicant or administrator is operating in a hazardous or injurious manner." This clarification is the result of three commenters objecting to proposed §7.1616(b). According to one commenter, proposed §7.1616(b) has a loophole to allow the Department to identify virtually any practice as "hazardous." This commenter recommended revising proposed §7.1616(b) to state "other activities similar in nature and effect to the activities identified in subsection (a)." A second commenter states that proposed §7.1616(b) is not specific enough about what may constitute "hazardous or injurious manner," and suggested revising proposed §7.1616 to be more specific, perhaps by cross-referencing the laundry list of improper acts contained in the Insurance Code §4151.301. A third commenter requested that proposed §7.1616(b) be deleted. This commenter objects to proposed §7.1616(b) as overly broad and over-reaching, and states that proposed §7.1616(b) does not specify the basis for determining that an applicant or administrator is operating in a hazardous or injurious manner. The Department declines to make the three commenters' suggested changes, in part, because the changes would negate the public policy benefits of providing regulatory guidance regarding compliance with the Insurance Code §4151.301(8). However, as a result of the concerns expressed by the three commenters, the Department has determined that it is necessary to revise proposed §7.1616(b) for purposes of clarity. The Department believes that the revisions to §7.1616(b) as adopted address the commenters' concerns.

The following paragraphs generally discuss the significant changes to the Insurance Code Chapter 4151 as a result of HB 472. They also provide a brief summary as well as an analysis of the reasons for the adopted rules, which include licensing, reporting, oversight, and contracting requirements necessary to implement the Insurance Code Chapter 4151.

Applicability of Adopted Rules. HB 472 enacts a significant change to the Insurance Code Chapter 4151 that specifically affects a person performing or offering to perform administrative services in connection with workers' compensation benefits in this state. HB 472 amends the definition of the term administrator in the Insurance Code §4151.001(1) to include a person that in connection with workers' compensation benefits: (i) collects premiums or contributions from residents of this state; and/or (ii) adjusts or settles claims for residents of this state. Consequently, a person that provides these workers' compensation administrative services that was previously excluded from the requirements of the Insurance Code Chapter 4151 may now be subject to the Chapter 4151 requirements. Since the enactment of HB 472, the Department has received several inquiries regarding the applicability of the Insurance Code Chapter 4151 and the implementing rules. As a result, the Department has determined that it is necessary to clarify who is subject to the requirements of the adopted new rules, based on the provisions of the Insurance Code Chapter 4151.

Adopted new §7.1601 specifies the scope and applicability of the adopted new rules. Adopted new §7.1601(a) provides that, except as otherwise provided by the Insurance Code Chapter 4151 or the new adopted rules, the rules apply to a person acting as or holding itself out as an administrator in any capacity. This applicability is regardless of whether the person holds another authorization pursuant to the Insurance Code or the Labor Code. The issue of whether a particular person is subject to the new subchapter depends entirely upon whether the person is acting as or holding itself out as an administrator, as that term is defined in adopted new §7.1602(1). Adopted new §7.1602(1) incorporates the statutory definition of the term administrator that is in the Insurance Code §4151.001(1). Section 4151.001(1) defines an administrator as a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Further, §4151.001(1) provides that the term includes: (i) a delegated entity under the Insurance Code Chapter 1272; and (ii) a workers' compensation health care network authorized under the Insurance Code Chapter 1305 that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. Section 4151.001(1) specifies that the term does not include a person described by the Insurance Code §4151.002. Thus, in order to determine whether a person meets the definition of the term administrator in §7.1602(1), it is necessary to evaluate the functions or services that the person is: (i) performing or providing; or (ii) offering to perform or provide. If the person qualifies for a specific exemption in the Insurance Code §4151.002 or §4151.0021, the person is not an administrator for the purpose of these rules. However, if the person does not qualify for one of these exemptions, and the person collects or offers to collect premiums or contributions from residents of this state or adjusts, settles, or offers to adjust or settle claims for residents of this state, in connection with annuities or life, health, accident, pharmacy, or workers' compensation benefits, the person meets the definition of administrator in the Insurance Code §4151.001(1) and new §7.1602(1). This is true, regardless of whether the person is also performing or providing other functions or services that subject the person to compliance with the Insurance Code and the Labor Code. Adopted new §7.1601(a) makes clear that a person acting as or holding itself out as an administrator may be simultaneously subject to the requirements of other provisions of the Insurance Code, the Labor Code, or rules adopted thereunder if the functions or services performed or offered by that person require such regulation. In such event, the person will be required to hold all appropriate authorizations pursuant to the Insurance Code or the Labor Code in order to perform or offer the regulated functions and services. This is because a single authorization issued pursuant to the Insurance Code or the Labor Code does not authorize a person to perform or offer any additional regulated functions or services than those specified by the authorization. Each authorization relates to specific functions or services regulated under specific Insurance Code or Labor Code provisions. Therefore, a

person must hold the applicable authorizations in order to perform or offer the corresponding regulated functions or services. The following example is provided for illustrative purposes. A person holds an authorization pursuant to the Insurance Code to operate a workers' compensation network in this state under the Insurance Code Chapter 1305. The person acts as or holds itself out as an administrator by settling a claim on behalf of the insurer that established or contracted with the network to provide health care services. In this example, the person will be simultaneously subject to the requirements of the Insurance Code Chapters 1305 and 4151 and the implementing rules for each chapter. The person will be required to hold a separate authorization under each of these chapters and be licensed as both a workers' compensation network and an administrator. This is because the authorization issued to the person under Chapter 1305 to operate a workers' compensation network in this state only authorizes the specific functions regulated under Chapter 1305. That specific authorization does not authorize the person to perform other activities that are regulated under other Insurance Code or Labor Code provisions. In order for the person to act as an administrator under the Insurance Code Chapter 4151, the person must hold a separate authorization issued pursuant to Chapter 4151. The person will be subject to the requirements of Chapter 1305 and the implementing rules for its functions related to operating a workers' compensation healthcare network. The person will also be simultaneously subject to the requirements of the Insurance Code Chapter 4151 and the implementing rules for acting as or holding itself out as an administrator. In order for the person to engage in each of these regulated activities, the person must hold separate authorizations issued under the applicable Insurance Code or Labor Code statutes and must comply with the rules adopted under each of those statutes. Adopted §7.1601(c) further reinforces this requirement by providing that an administrator must meet the requirements of the Insurance Code Chapter 4151 and the adopted new rules in addition to any other requirements that apply to that person as: (i) a delegated third party of a health maintenance organization (HMO) under the Insurance Code Chapter 1272; (ii) a workers' compensation healthcare network under the Insurance Code Chapter 1305; (iii) a qualified claims servicing contractor under the Labor Code Chapter 407; or (iv) an administrator or service company under the Labor Code Chapter 407A.

Adopted new §7.1601(b) is necessary to effectuate the legislative intent of HB 472 by providing uniform application of the requirements of the Insurance Code Chapter 4151 to all administrators to which that chapter applies. As such, new §7.1601(b) requires an administrator performing administrative services on behalf of an HMO pursuant to the Insurance Code Chapter 1272 or a workers' compensation self-insurance group (group) pursuant to the Labor Code Chapter 407A to comply with the same requirements under the Insurance Code Chapter 4151 and the adopted new rules as an administrator performing administrative services on behalf of an insurer or plan sponsor. This will ensure that, to the extent possible, all administrators are treated equally under the Insurance Code Chapter 4151.

Adopted new §7.1601(d) makes clear that the new rules do not apply to a person acting as or holding itself out as an administrator for an The Employee Retirement Income Security Act of 1974 (ERISA) qualified employee welfare benefit plan that is exempt from regulation by this state. However, this exemption only applies with respect to the particular employee welfare benefit plan the person is administering. The following two examples are offered for illustrative purposes. In the first example, a person acts as or holds itself out as an administrator for several ERISA qualified employee welfare benefit plans offered by self-insured employers. The person, however, does not act as or hold itself out as an administrator for any other entity. Under §7.1601(d), the person will not be subject to the new subchapter in any capacity, provided that: (i) each of the ERISA qualified employee welfare benefit plans for which the person acts as or holds itself out as an administrator is exempt from regulation by this state; and (ii) the person does not act as or hold itself out as an administrator for any other entity. In the second example, a person acts as or holds itself out as an administrator on behalf of an insurer and a group and for several ERISA qualified employee welfare benefit plans offered by self-insured employers. In this example, adopted §7.1601(d) clarifies that the person will not be subject to the new rules with respect to the ERISA qualified employee welfare plans, provided that each of the ERISA qualified employee welfare benefit plans for which the person acts as or holds itself out as an administrator is exempt from regulation by this state. In this same example, however, the person will be subject to the requirements of the new rules for acting as or holding itself out as an administrator on behalf of the insurer and the group. This is because, under §7.1601(d), the new rules are not applicable only to the extent that the administration of an ERISA qualified employee welfare plan that is exempt from state regulation is involved. The administration of any other type of plan offered, established, or maintained by any other type of entity is not exempt from compliance with the adopted new rules under §7.1601(d).

Administrator Contractors and Administrator Subcontractors. The term administrator contractor is defined in adopted new §7.1602(3). The term administrator subcontractor is defined in adopted new §7.1602(4). An administrator contractor may choose to delegate some or all of its administrative functions to an administrator subcontractor. Neither the Insurance Code Chapter 4151 nor the adopted rules prohibit the delegation of an administrative service from one administrator to another administrator. However, §7.1603(b) is necessary to clarify the responsibilities and obligations of an administrator contractor and an administrator subcontractor in situations where an administrative service is delegated from one administrator to another administrator, as the term administrator is defined in the Insurance Code §4151.001(1). Under adopted new §7.1603(b), both an administrator contractor and an administrator subcontractor are required to hold a certificate of authority under the Insurance Code Chapter 4151. This new requirement is necessary to ensure appropriate oversight of all administrators regulated under the Insurance Code Chapter 4151. The more times that a particular function is delegated from one administrator to another administrator, the greater the risk of non-performance or inadequate performance of that function. Additionally, because administrators are authorized under Chapter 4151 to: (i) collect premium and contributions from Texas residents; and (ii) adjust and settle claims for Texas residents, administrators often have access to and control of fiduciary bank accounts and other accounts designated for claims payment. While the authority of an administrator is largely determined by the particular person for which the administrator performs services, many administrators have great discretion in carrying out their delegated duties. Further, administrators often directly interact with Texas consumers, providers, physicians, staff members, and adjusters. Requiring all administrators, including administrator contractors and administrator subcontractors, to comply with the requirements of the Insurance Code Chapter 4151 and these rules will ensure appropriate oversight and more efficient regulation of all administrators. This should better

protect the interests of the public and insurance consumers in this state.

Reporting Requirements. New §§7.1606, 7.1607, and 7.1609 are necessary to implement the reporting requirements added to Chapter 4151 of the Insurance Code by the enactment of HB 472. New §7.1606 and §7.1607 implement the Insurance Code §4151.052(b). Section 4151.052(b) requires an applicant for a certificate of authority or a certificate holder (administrator) under the Insurance Code Chapter 4151 to notify the Department of a change of control in the applicant's or administrator's ownership or of any other fact or circumstance affecting the applicant's or administrator's qualifications for a certificate of authority. Section 4151.211 requires a person to seek approval from the Department in order to acquire an ownership interest resulting in a change of control of an administrator under Chapter 4151. Section 4151.211 also grants the Department the authority to disapprove a request for an acquisition of control. Further, if the Commissioner has not proposed to deny a request for an acquisition of control before the 61st day after the date on which the Department receives the required information, the request is deemed approved.

Adopted new §7.1606 is necessary to prescribe notification requirements related to a change in control of an applicant or administrator. In order to clarify how the notification requirements apply to a change in control of an applicant or administrator, §7.1606(a) defines the meaning of term "control"; illustrates the manner in which control may be possessed; and describes when control exists for purposes of new §7.1606. Section 7.1606(b) requires an applicant or administrator to notify the Department in writing of a change of control in the ownership of the applicant or administrator within a specified time frame. The §7.1606(b) notice requirement is triggered when there is a change in the control of an applicant or administrator, including a change in any of the circumstances specified in §7.1606(a). The additional guidance provided to applicants and administrators by §7.1606(a) should assist them in identifying reportable changes of control in their own organizations. Adopted new §7.1606(c) prohibits an applicant or administrator from filing the notification required by §7.1606(b) until a request for an acquisition of control has been approved under the Insurance Code §4151.211. This requirement is necessary to harmonize the provisions of the Insurance Code §4151.052(b) and §4151.211. Section 4151.052(b) requires an applicant or administrator to notify the Department of a change of control in the applicant's or administrator's ownership not later than the 30th day after the effective date of the change. However, §4151.211 prohibits a person from acquiring an ownership interest in an administrator unless the person has first filed specified information with the Department and the Department has approved the filed information. The harmonization in §7.1606(c) serves two important purposes. First, it provides the Department an opportunity to evaluate a requested acquisition of control of an applicant or administrator under the Insurance Code §4151.211 prior to the change taking place. The Department's review of a requested acquisition of control of an applicant or administrator is essential to ensure that the new acquisition does not impede the ability of the applicant or administrator to comply with the requirements of the Insurance Code Chapter 4151 or these rules. Further, it ensures that the proposed acquisition of control is appropriate and in the best interest of the public and the insurance consumers of this state. Adopted new §7.1606(c) also provides an opportunity to confirm whether an approved acquisition of control of an applicant or administrator actually occurs. This is necessary for the Department to remain informed of the significant changes in the operations of the applicant or administrator. This should result in more effective regulation of the applicant or administrator.

Adopted new §7.1607 is necessary to emphasize the importance of reporting material changes in facts and circumstances to the Department and maintaining continued compliance with the requirements of the Insurance Code Chapter 4151 and the new rules. First, adopted new §7.1607(a) defines the phrase "material change in fact or circumstance." It also provides a non-exhaustive list of examples of certain material changes in facts or circumstances that require notification to the Department under adopted new §7.1607(b) and (c). This sample list is provided to assist applicants and administrators in identifying specific changes in the facts or circumstances of their own organizations that require notification to the Department. Adopted new §7.1607(b) requires an administrator to notify the Department in writing of a material change in fact or circumstance within a specified time frame. This required notification is necessary to provide the Department with the opportunity to evaluate the reported change in order to determine its likely effect on the administrator. Further, if the reported change in fact or circumstance adversely reflects upon the integrity of the administrator, the Department must be able to take any necessary action as quickly as possible in order to prevent any injury to the public and insurance consumers of this state. Except as provided by §7.1606(b), §7.1607(c) requires an applicant to continually update the information filed in its initial application for a certificate of authority. This includes notifying the Department in writing of a material change in fact or circumstance, while the application is pending with the Department. This required notification is necessary to allow the Department to accurately assess an applicant's fitness for licensure. Further, if a reported change in the information filed in an applicant's initial application for a certificate of authority prevents an applicant from fulfilling the minimum requirements necessary for the Department to approve its application, the Department must be able to identify and assess those situations quickly and accurately. Adopted new §7.1607(d) and (e) are necessary to address an applicant's or administrator's continued compliance with the requirements of the Insurance Code Chapter 4151 and these rules. Adopted new §7.1607(d) requires an applicant or administrator to meet the requirements of Chapter 4151 and these rules as those requirements apply to any material change in fact or circumstance identified by an administrator pursuant to §7.1607(b) and to any change in information identified by an applicant pursuant to §7.1606(c). Adopted new §7.1607(e) requires an applicant and an administrator to continuously maintain the qualifications necessary to obtain a certificate of authority under Chapter 4151. These new requirements ensure that an applicant and an administrator maintain the integrity of their organizations by meeting the minimum statutory and regulatory requirements applicable to their organizations at all times. This includes when certain facts and circumstances affecting those organizations change over time. Requiring all applicants and administrators to continually monitor their own organizations for compliance with applicable statutory and regulatory requirements will help ensure the financial health and integrity of the administrators in this state.

Adopted new §7.1609 is necessary to implement the annual reporting requirements of HB 472 and to clarify the Insurance Code §4151.205(f). Section 7.1609(a), (b), and (c) are necessary to prescribe the general requirements that apply to annual report filings under the Insurance Code §4151.205. Adopted new §7.1609(d) is necessary to clarify the exemption provided by the

Insurance Code §4151.205(f) and to establish the certification requirements prescribed by the Insurance Code §4151.205(f). HB 472 amends the Insurance Code §4151.205(a) to require an administrator to file an annual report with the Commissioner no later than June 30 each year. Pursuant to the Insurance Code §4151.205(a) - (d), the annual report must: (i) cover the preceding calendar year; (ii) include an audited financial statement performed by an independent public accountant; and (iii) include notes or attachments to the financial statement that reflect the complete name and address of each insurer in this state with which the administrator had an agreement during the preceding fiscal year. The Insurance Code §4151.205(f) exempts an administrator who meets certain conditions from filing the audited financial statement required by §4151.205(c). Section 4151.205(c) requires the exempted administrator to file a financial statement with the Commissioner, certified in the manner prescribed by Commissioner rule.

After the enactment of HB 472, the Department received inquiries regarding the applicability of the exemption allowed by the Insurance Code §4151.205(f). As a result, the Department is adopting new §7.1609(d)(1) to clarify that the exemption in the Insurance Code §4151.205(f) applies only to compensation received by an administrator for providing administrative services in Texas during the preceding calendar year. Thus, an administrator may qualify for the exemption in adopted new §7.1609(d)(1) if the administrator earns less than $10 million in compensation for providing administrative services in Texas, regardless of the amount of compensation the administrator earns for providing administrative services in other jurisdictions. Adopted new §7.1609(d)(1) is necessary to provide small administrators and administrators with limited business in Texas the less costly option of filing a certified financial statement with the Department instead of an audited financial statement performed by an independent public accountant as part of their annual report. Of the 751 administrators currently licensed by the Department, the Department estimates that 734 may qualify for the exemption in adopted new §7.1609(d)(1) and may be eligible to utilize that option for the annual report filing due June 30, 2009. By providing a less costly filing option for these administrators, the Department anticipates that many of these administrators may be able to realize additional cost savings. Although §7.1609(d)(1) provides an exemption from the financial filing requirements of §7.1609(c) for certain qualifying administrators, the Department's ability to effectively regulate these qualifying administrators will not be negatively affected by the use of this exemption. In an effort to maintain effective regulation of these administrators and to ensure that all necessary financial information is timely filed with the Department, the Department is adopting new §7.1609(d)(2) and (3). Section 7.1609(d)(2) requires an administrator qualifying for the exemption in §7.1609(d)(1) to file an alternative financial statement with the Department that includes a certification form and is verified by at least two officers or other comparable responsible persons of the administrator. The certification form, Form Number FIN 490, Certification of Financial Statement, is adopted by reference in §7.1609(b)(1)(D); the form prescribes the text and format of the required certification. The §7.1609(d)(2) requirement is important for several reasons. First, it makes clear that no administrator is completely exempt from filing a financial statement with the Department. While compliance with the requirements of new §7.1609(d)(2) may be less costly or less onerous than compliance with the requirements of §7.1609(c), an administrator qualifying for the exemption in §7.1609(d)(1) is nonetheless required to file a sufficient financial statement with the Department under §7.1609(d)(2). This minimum threshold enables the Department to exercise the necessary oversight over the financial health of an administrator qualifying for the exemption in §7.1609(d)(1). Second, §7.1609(d)(2) requires at least two officers or other comparable responsible persons of an administrator qualifying for the exemption to execute a notarized certification and to verify the financial statement filed with the Department. This requirement helps to ensure that the financial statements submitted to the Department are properly prepared, reviewed, and verified. Additionally, new §7.1609(d)(2) requires some involvement and oversight from the responsible persons of the administrator. This should result in more efficient management of the administrator. Further, adopted new §7.1609(d)(3) requires that an administrator qualifying for the exemption in new §7.1609(d)(1) meet all other requirements of new §7.1609. This requirement enables the Department to appropriately review the overall operating condition of an administrator, including its financial strength, claims payment history, account management, and compliance with applicable statutes, rules, and contract provisions, regardless of the type of financial statement filed by the administrator as part of its annual report. Adopted new §7.1609(e) provides that the Commissioner may request additional information as necessary to determine if an administrator is operating or conducting business in a potentially hazardous or injurious manner. This new requirement is necessary to enable the Department to earlier detect an administrator's potentially hazardous or injurious operating condition. HB 472 enacts §4151.301(8), which permits the Department to take appropriate action to address situations in which an administrator is in a financial condition or is operating or conducting business in a manner that would render further transaction of business in this state hazardous or injurious to the public or insurance consumers of this state. The new requirement is important in ensuring that corrective actions can be taken at the earliest possible point in time to alleviate or prevent harm to the public and insurance consumers of this state as a result of an administrator's hazardous or injurious operating condition.

Oversight Requirements. While the use of administrators may provide insurers, HMOs, plan sponsors, and groups with cost savings and access to persons with specialized claims payment and management skills, it also presents special challenges. The authority of an administrator is largely determined by the particular insurer, HMO, plan sponsor, or group that has delegated duties to the administrator. As a result, many administrators are given wide discretion in carrying out their delegated duties. Depending upon each insurer's, HMO's, plan sponsor's, or group's individual preference, an administrator may perform a wide variety of statutorily required duties on behalf of the insurer, HMO, plan sponsor, or group. Administrators are often delegated the responsibility of timely paying medical benefits and workers' compensation benefits on behalf of insurers, HMOs, plan sponsors, and groups. Many administrators also have control over an insurer's, HMO's, plan sponsor's, or group's books and records and claims files. While such delegation of discretion may be appropriate in many instances, the monitoring and oversight of these administrators is essential in ensuring their compliance with applicable statutes, rules, and contract provisions for the functions they perform. New §§7.1611, 7.1612, 7.1615, and 7.1616 are adopted to address the monitoring and oversight of administrators.

First, §7.1611 is necessary to implement the review and on-site audit requirements of the Insurance Code §4151.1042. HB 472

enacts the Insurance Code §4151.1042, which requires an insurer to ensure competent administration of its programs. Further, the Insurance Code §4151.1042 requires an insurer to conduct a semi-annual review of the operations of each of its administrators that, on the insurer's behalf, administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders. Additionally, the Insurance Code §4151.1042 requires an insurer to conduct a biennial on-site audit of the operations of each of its administrators that, on the insurer's behalf, administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders. The new requirements of §7.1611 impose a minimal level of oversight and responsibility on each insurer that utilizes the services of an administrator. These new requirements are significant because an insurer retains the ultimate responsibility and accountability for each function it delegates to an administrator. Thus, it is imperative that an insurer appropriately monitor the activities of its administrators to ensure their compliance with the Insurance Code, the Labor Code, and rules adopted thereunder. An insurer's regular oversight over its administrators is important. Therefore, new §7.1611(a) requires an insurer, no less than two times each fiscal year, to review the operations of each of its administrators that, in the aggregate, administers benefits in Texas on its behalf for more than 100 certificate holders, injured employees, plan participants, or policyholders. Additionally, §7.1611(b) requires an insurer, no less than once every two fiscal years, to conduct an on-site audit of each of its administrators that, in the aggregate, administers benefits in Texas on its behalf for more than 100 certificate holders, injured employees, plan participants, or policyholders. New §7.1611(d) and (e) prescribe the minimum information that an insurer must review during the required review or on-site audit. This includes a review of an administrator's compliance with the contract between the administrator and the insurer and the administrator's performance of claims adjudication and payment. The new requirements also require an insurer to develop a written summary of the objectives and scope of the review or on-site audit and a summary of the results of the review or on-site audit. Each summary must include a corrective action plan addressing any deficiencies found during the review or on-site audit. These new requirements are important for several reasons. First, reviewing the prescribed information should enable an insurer to better assess its ability to meet its obligations under the Insurance Code, Labor Code, and rules adopted thereunder. Additionally, it is anticipated that an insurer's regular review of the required information will enable the insurer to foresee potential financial problems or solvency issues at a much earlier date, so that corrective action can be taken immediately. Further, new §7.1611 emphasizes the importance of establishing performance goals for administrators and reviewing the performance of the administrators to determine if those goals are being met. By regularly monitoring and overseeing its administrators, an insurer should obtain a better idea of its own capabilities, strengths, and weaknesses. This should result in financially healthier insurers. Additionally, if an insurer already has an audit plan in place to oversee its administrators, it may already meet several of the new requirements. In these situations, an insurer must only ensure that its current audit plan is modified to address the new requirements that are not currently being addressed in its audit plan.

Administrative services are sometimes delegated from one administrator to another administrator. Neither the Insurance Code Chapter 4151 nor the adopted new subchapter prohibits such a re-delegation of administrative services. However, an insurer remains ultimately responsible for the performance of all of its delegated functions, regardless of whether those functions are performed by an administrator contractor or by an administrator subcontractor. As previously discussed in this adoption, in a situation where an administrator contractor further delegates the performance of its administrative functions to an administrator subcontractor, both the administrator contractor and the administrator subcontractor qualify as an administrator under adopted new §7.1602(1). In such situations, because the administrator contractor and the administrator subcontractor are both performing delegated functions on behalf of an insurer, it is necessary for the insurer to regularly monitor and oversee the activities of both the administrator contractor and the administrator subcontractor. An insurer remains responsible for monitoring and overseeing the activities of all of its administrators, including its administrator contractors and administrator subcontractors. However, it may be appropriate for the administrator contractor that delegates the performance of a specific function to an administrator subcontractor to oversee the performance of that administrator subcontractor on the insurer's behalf. Therefore, §7.1611(g) provides an insurer with the option of meeting the §7.1611 monitoring and oversight requirements for an administrator subcontractor by reviewing and auditing its administrator contractor only. However, an insurer may utilize this option only if two requirements are met. First, an administrator contractor must supply the insurer with all the necessary and relevant information relating to a particular administrator subcontractor. Second, the information provided to the insurer by the administrator contractor must indicate that no evidence of material non-compliance by the administrator subcontractor exists. If these two requirements are met, an insurer may utilize the option provided by §7.1611(g). However, if these two requirements are not met, an insurer must review and audit each administrator subcontractor that does not meet the two requirements in accordance with the §7.1611 review and audit requirements for its administrator contractors. New §7.1611(g) serves two important purposes. First, the insurer is requiring its administrator contractors to take an active role in ensuring that each administrator subcontractor performs its delegated administrative functions professionally, competently, and in compliance with all applicable statutes, rules, and contract provisions. Second, the insurer may be able to realize the benefit of consolidating the review of all of its administrators. A consolidated review may result in cost savings for the insurer while still ensuring an appropriate level of oversight of all administrators.

Because administrators are authorized under the Insurance Code Chapter 4151 to collect premiums, contributions, return premiums, and return contributions (premiums) from residents of this state, adopted new §7.1612 prescribes requirements intended to provide additional oversight over the administrators that collect these premiums. First, pursuant to the Insurance Code §4151.106, §7.1612 requires an administrator to hold all premium in a fiduciary capacity. This requirement is necessary to implement the fiduciary duty requirement imposed by the Insurance Code §4151.106(b) upon an administrator that collects premiums on behalf of an insurer, HMO, plan sponsor, or group. Second, §7.1612 prescribes the general requirements related to the establishment and maintenance of fiduciary accounts used to hold collected premiums. For example, new §7.1612(e) requires an administrator to maintain a fiduciary bank account at a financial institution that is organized under the laws of the United States. It must also be regulated under the laws of United States federal or state authorities having regulatory authority over banks and trust companies. This requirement is necessary to ensure that collected premiums are maintained in

an accessible, stable, and secure environment at all times. Further, §7.1612(e) permits a fiduciary bank account to consist only of one or more of the following types of investments: (i) cash and cash equivalents; (ii) non-assessable money market mutual funds that are primarily invested in United State government securities; and (iii) other investments of substantially similar quality, as approved by the Commissioner. This requirement is necessary to preserve the integrity and stability of collected premiums and to ensure immediate access to those premiums, should such access be required.

The remaining provisions of §7.1612 are necessary to regulate other administrator activities related to fiduciary bank accounts. New §7.1612(f) requires an administrator to properly maintain detailed accounting records documenting all deposits and withdrawals from a fiduciary account. This requirement ensures that each collected premium is properly accounted for and transferred to the appropriate insurer, HMO, plan sponsor, or group. New §7.1612(g) requires an administrator to provide a copy of the records relating to the account activity of an insurer, HMO, plan sponsor, or group in a fiduciary bank account to the insurer, HMO, plan sponsor, or group, upon its reasonable request. This requirement is necessary to provide an insurer, HMO, plan sponsor, or group with continuing access to a fiduciary account maintained by an administrator on its behalf. This enables the insurer, HMO, plan sponsor, or group to properly oversee the activities of the administrator and to ensure that the premiums collected on its behalf are properly accounted for and maintained. Finally, new §7.1612(i) prohibits an administrator from paying a claim from a fiduciary bank account; this prohibition is consistent with the statutory prohibition in the Insurance Code §4151.109. It further ensures that all collected premiums are maintained in fiduciary accounts that are separate and distinguishable from any account used by an administrator to pay a claim on behalf of an insurer, HMO, plan sponsor, or group.

Depending upon the duties that an administrator performs on behalf of an insurer, HMO, plan sponsor, or group, an administrator may have access to, or control over, the books and records of an insurer, HMO, plan sponsor, or group. In such situations, it is necessary for the insurer, HMO, plan sponsor, or group to have continuing access to its books and records, even while the books and records are in the possession of an administrator. The Department is aware of situations in which administrators have refused to timely return the books and records of an insurer or have denied an insurer access to its own books and records altogether. These situations typically involved an insurer that terminated the employment of one administrator in order to employ the services of another administrator. These situations also usually occurred when there was an inadequate written agreement between the parties, or where the written agreement between the parties did not sufficiently address transition and ownership issues. An administrator's refusal to provide an insurer, HMO, plan sponsor, or group with access to its own books and records can have widespread and disastrous results, especially with regard to the payment of claims. An insurer, HMO, plan sponsor, or group simply cannot comply with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder without knowing which of its claims have been paid and which of its claims remain outstanding. Additionally, an insurer, HMO, plan sponsor, or group may be put into a potentially hazardous financial condition if it is unable to access its financial books and records. New §7.1615 is adopted in an effort to prevent these situations from occurring. It addresses the continuity of services and ownership of books and records. Further, new §7.1615 is necessary to implement the Insurance Code §4151.103(d). Section 4151.103(d) provides that the Commissioner shall adopt rules to address the transfer of records from one administrator to another. The new requirements are also necessary to ensure that an insurer, HMO, plan sponsor, or group retains continual access to its own books and records following the termination of its relationship with an administrator. First, new §7.1615(a) requires an administrator to provide a complete and accurate original set or a complete and accurate copy or image of the original set of an insurer's, HMO's, plan sponsor's, or group's books and records to a successor administrator. If there is not a successor administrator or the successor administrator is unknown at the time of the required transfer, then they must be provided to the insurer, HMO, plan sponsor, or group. In both cases, the books and records must be provided no later than 30 days from the date of the termination of the relationship or written agreement between the insurer, HMO, plan sponsor, or group and the administrator, unless otherwise approved by the Commissioner. New §7.1615(b) requires the books and records to be transferred in an organized and usable manner. These new requirements are designed to prevent potentially hazardous financial conditions from occurring during transition periods and to alleviate delays in claims payments. New §7.1615(d) requires an administrator to provide written notice to the Department of the termination of a relationship or written agreement with an insurer, HMO, plan sponsor, or group no later than 30 days from the date the administrator first learns of the termination. This new requirement provides the Department with the opportunity to monitor specific transition periods to ensure that claims are timely paid, premiums are appropriately collected and transferred, and the financial condition of insurers, HMOs, plan sponsors, groups, and administrators remain stable. New §7.1615(e) is necessary to address situations in which an administrator contractor has further delegated the performance of its administrative duties to an administrator subcontractor. In these situations, it is likely that the administrator contractor will have provided the administrator subcontractor with a portion of the books and records of the insurer, HMO, plan sponsor, or group so that the administrator subcontractor may appropriately perform its delegated duties. As previously discussed in this adoption, in a situation where an administrator contractor further delegates the performance of its administrative functions to an administrator subcontractor, both the administrator contractor and the administrator subcontractor qualify as an administrator under §7.1602(1). As such, the requirements of new §7.1615 apply equally to the administrator contractor and the administrator subcontractor. However, the termination of the relationship between an administrator contractor and an administrator subcontractor may not necessarily affect the relationship between the administrator contractor and the insurer, HMO, plan sponsor, or group. In such situations, it may be appropriate for the administrator contractor to retain its relationship with the insurer, HMO, plan sponsor, or group and to re-delegate the performance of certain delegated functions to a new administrator subcontractor. Therefore, when an administrator subcontractor's relationship or written agreement with an administrator contractor terminates, new §7.1615(e) provides the administrator subcontractor with an option. The administrator subcontractor may comply with the requirements of new §7.1615 by providing a complete and accurate original set or a complete and accurate copy or image of the original set of the insurer's, HMO's, plan sponsor's, or group's books and records to the administrator contractor. The administrator subcontractor must also provide written notice to the Department of the termination of the relationship or written agreement with the adminis-

trator contractor, no later than 30 days from the date the administrator subcontractor first learns of the termination. This requirement serves two important purposes. First, it ensures that the administrator contractor maintains possession over the books and records that were originally provided to the administrator subcontractor on behalf of the insurer, HMO, plan sponsor, or group. Second, it allows the administrator contractor the opportunity to re-delegate the performance of certain delegated functions to another administrator subcontractor, should it choose to do so. Should an administrator subcontractor choose not to utilize the option provided by §7.1615(e), then that administrator subcontractor is required to meet the requirements of §7.1615 in the same manner that an administrator contractor is required to meet the requirements of §7.1615.

Finally, adopted new §7.1616 addresses circumstances that may indicate that an applicant or administrator is operating in a potentially hazardous or injurious manner. HB 472 enacts the Insurance Code §4151.301(8). This statute permits the Department to take appropriate action if an applicant or administrator is in a financial condition or is operating or conducting business in a manner that would render further transaction of business in this state hazardous or injurious to the public or insurance consumers of this state. The new requirements are important in identifying applicants' and administrators' potentially hazardous or injurious conditions so that corrective actions, if necessary, may be taken at the earliest point in time to alleviate or prevent harm to the public and insurance consumers of this state. New §7.1616(a) provides eight illustrative examples of conduct that may indicate that an applicant or administrator is operating or conducting business in a potentially hazardous or injurious manner. These examples, however, are not exhaustive. New §7.1616(b) makes clear that the Commissioner may consider other factors and conditions, as determined by the Commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state that are not specified in the eight examples to determine whether an applicant or administrator is operating in a potentially hazardous or injurious manner. Any of the specified factors or conditions in new §7.1616(a) and any of the factors or conditions determined by the Commissioner pursuant to new §7.1616(b) may be a basis for the Commissioner to initiate regulatory action against an administrator or applicant under the Insurance Code. However, the factors and conditions specified in new §7.1616(a) and new §7.1616(b) do not necessarily indicate that an applicant or administrator is operating in a potentially hazardous or injurious manner. Rather, they are factors and conditions that may be considered by the Department in determining whether an applicant or administrator is operating in a potentially hazardous or injurious manner. Also, in evaluating any of these factors or conditions, all circumstances concerning the administrator's or applicant's condition, activities, and operations must be evaluated in order to determine whether an administrator or applicant is operating or conducting business in a potentially hazardous or injurious manner. For example, if an applicant or an administrator fails to file a financial statement with the Department as illustrated in new §7.1616(a)(1), the Department may contact the applicant or administrator and request additional information. Based upon the applicant's or administrator's response to the Department, the Department may further investigate the situation to determine if any preventative or correction action is needed or the Department may determine that the issue has been resolved. A final determination of whether an applicant or administrator is operating in a potentially hazardous or injurious manner may depend upon many factors and conditions, including one or more factors or conditions enumerated in §7.1616. However, a final determination of whether an applicant or administrator is operating in a potentially hazardous or injurious manner is not necessarily dependent upon a factor or condition enumerated in §7.1616. Section 7.1616 is intended to provide applicants and administrators guidance in managing their own organizations. By providing applicants and administrators with illustrative examples of situations that may constitute or lead to potentially hazardous or injurious operating conditions, the Department anticipates that applicants and administrators will take preventative steps to avoid these types of situations. This should result in financially healthier and more stable applicants and administrators.

Contracting Requirements. Because an insurer retains ultimate responsibility and accountability for the functions performed by its administrators, it is imperative that each insurer monitor the activities of its administrators and maintain appropriate oversight over its administrators. Therefore, adopted §7.1613 is necessary to establish minimum contracting requirements between an insurer and an administrator. It requires each administrator performing administrative services in Texas on behalf of an insurer to enter into a written agreement with that insurer. Section 7.1613(c), (d), (e), and (f) prescribe the minimum requirements, obligations, and provisions that must be included in each written agreement between an insurer and an administrator. These new requirements are necessary for several reasons. First, under the new requirements, insurers are required to establish written expectations for their administrators. This requirement is necessary to ensure that each party clearly understands their responsibilities and obligations under the written agreement. Further, it is easier for an insurer to monitor its administrators to determine if they are performing their delegated functions in accordance with the expectations of the insurer once those expectations have been memorialized in a written agreement. Second, the new requirements require insurers and administrators to address compliance with other important new requirements of the subchapter in their written agreement. This includes the obligation of an insurer to review and audit its administrators under §7.1611 and the obligation of an administrator to notify the Department and timely transfer the books and records of an insurer upon the termination of the relationship with the insurer under §7.1615. It is especially important for an insurer and an administrator to address these matters in their written agreements because of the complexity and potential complications related to these issues. Finally, as previously discussed, in a situation where an administrator contractor further delegates the performance of its administrative functions to an administrator subcontractor, both the administrator contractor and the administrator subcontractor qualify as an administrator under §7.1602(1). As such, the requirements of §7.1613 apply equally to the administrator contractor and the administrator subcontractor. However, an administrator contractor may delegate a few, specific duties to an administrator subcontractor and may retain a contractual responsibility for the performance of those duties, despite the delegation of those duties to the administrator subcontractor. Additionally, some insurers may permit their administrator contractors to further delegate duties to administrator subcontractors, provided that the administrator contractors retain responsibility for the performance of those duties. As previously explained, each insurer retains the ultimate responsibility for all of its delegated duties, regardless of whether they are performed by an administrator contractor or an administrator subcontractor. It may be appropri-

ate, however, in some instances for an administrator contractor to enter into a written agreement with an administrator subcontractor for the performance of certain delegated duties without the insurer entering into a separate written agreement with that particular administrator subcontractor. In these instances, the insurer is required to enter into a written agreement with the administrator contractor pursuant to §7.1613(a). Therefore, §7.1613(b) provides an administrator subcontractor with the option of meeting the contracting requirements of §7.1613 by entering into a written agreement with an administrator contractor only. This is permissible only if the written agreement meets the requirements of the Insurance Code Chapter 4151 and §7.1613. This gives insurers the flexibility of entering into a written agreement with an administrator contractor and permits that administrator contractor to further delegate certain duties to an administrator subcontractor without the insurer having to enter into a separate agreement with the administrator subcontractor. This option is particularly useful when the duties performed by the administrator subcontractor are limited in scope. Because of the insurer-administrator contractor written agreement required under §7.1613(a), the insurer will be able to oversee the administrator contractor and monitor its activities. Further, new §7.1613(b) will enable the administrator contractor to oversee and monitor the performance of each of its administrator subcontractors through the written agreement that the administrator contractor has with each administrator subcontractor. This approach is intended to ensure that each administrator, whether an administrator contractor or an administrator subcontractor, is properly monitored by another responsible person. Should an administrator subcontractor choose not to utilize the option provided by new §7.1613(b), then that administrator subcontractor is required to meet the requirements of new §7.1613 in the same manner that an administrator contractor is required to meet the requirements of new §7.1613.

Application, Annual Report, and Exam Fees. New §7.1604(b)(2) adopts a non-refundable application filing fee of $1,000. The Insurance Code §4151.206(a)(1) provides that an applicant or administrator shall pay, in an amount to be determined by the Commissioner, a filing fee not to exceed $1,000 for processing an original application for a certificate of authority. The Department has determined that the new application fee amount is appropriate and necessary for the following reasons: (i) the new application fee amount is needed to offset the Department's costs for processing and reviewing administrator applications, including the new applications that will be required annually as a result of HB 472; (ii) the Department has not increased the current application fee amount since 1990, although the Department's responsibilities for the general administration of Chapter 4151 and the costs for reviewing and processing administrator applications have increased since that time; and (iii) the new application fee amount is more consistent with other fee amounts charged by the Department for reviewing and processing other similar applications and issuing other authorizations.

New §7.1609(b)(2) adopts a non-refundable annual report filing fee of $200. This fee must accompany the annual report required to be filed by the administrator no later than June 30 each year. The Insurance Code §4151.206(a)(3) provides that an administrator shall pay, in an amount to be determined by the Commissioner, a filing fee not to exceed $200 for an annual report. The Department has determined that the $200 annual report fee amount is appropriate and necessary for the following reasons: (i) the new annual report fee amount is needed to offset the Department's costs for processing and reviewing administrator annual reports, including the new reports that will be required annually as a result of HB 472; (ii) the Department has not increased the current annual report fee amount since 1990, although the Department's responsibilities for the general administration of Chapter 4151 and the Department's costs for reviewing and processing administrator annual reports have increased since that time; and (iii) the new annual report fee amount is more consistent with other fees charged by the Department for reviewing and processing other entity's annual reports. New §7.1617(a) adopts a non-refundable examination fee of $500, as authorized by the Insurance Code §4151.206(a)(2). The Insurance Code §4151.206(a)(2) provides that an administrator shall pay, in an amount to be determined by the Commissioner, a fee not to exceed $500 for an examination under the Insurance Code §4151.201. The Department has determined that the $500 fee is appropriate and necessary for the following reasons: (i) the new exam fee amount is needed to offset the Department's costs for examining an administrator, including workers' compensation administrators that are now subject to examination under Chapter 4151; (ii) the Department has not increased the current exam fee amount since 1990, although the Department's costs for examining an administrator are likely to exceed that fee amount; and (iii) the new exam fee amount is still substantially less than other examination fees charged by the Department for conducting examinations of other entities.

Financial Statements under the Education Code. Section 7.1610 is necessary to implement the Education Code §22.004(h), concerning audited financial statements. The new section does not implement any new requirements resulting from the enactment of HB 472. The new section replaces existing §7.1617, relating to School District Group Health Coverage Contracts. The Department simultaneously is adopting the repeal of existing §7.1617, which also was published in the December 5, 2008, issue of the *Texas Register.* The Education Code §22.004(h) provides that an audited financial statement provided under §22.004 must be made in accordance with rules adopted by the Commissioner of Insurance or with generally accepted accounting principles, as applicable. The Education Code §22.004(g) provides that an insurer, a group hospital service corporation, or a health maintenance organization that issues a policy or contract under the Education Code §22.004 and any person that assists the school district in obtaining or managing the policy or contract for compensation shall provide an annual audited financial statement to the school district showing the financial condition of the insurer, group hospital service corporation, organization, or person. Section 7.1610(a) is necessary to specify that the section applies only to an insurer or HMO that: (i) meets the requirements of §7.1605 (relating to Notification Requirements); and (ii) is subject to the requirements of the Education Code §22.004(g). Section 7.1610(b) is necessary to specify how an administrator meeting the requirements of §7.1610(a) may comply with the requirement for an audited financial statement under the Education Code §22.004(h).

HOW THE SECTIONS WILL FUNCTION.

§7.1601. Scope. Adopted new §7.1601(a) specifies that, except as otherwise provided by the new subchapter or the Insurance Code Chapter 4151, the new subchapter applies to a person acting as or holding itself out as an administrator in any capacity, regardless of whether the person holds another authorization under the Insurance Code or the Labor Code. In accordance with the Insurance Code §1272.058 and the Labor Code §407A.009, new §7.1601(b) requires an administrator performing administrative services on behalf of an HMO or a group to meet the same

requirements under the Insurance Code Chapter 4151 and the new subchapter as an administrator performing administrative services on behalf of an insurer or plan sponsor. New §7.1601(c) requires a person acting as or holding itself out as an administrator to meet the requirements of the Insurance Code Chapter 4151 and the new subchapter. This is in addition to any other requirements applicable to that person under the Insurance Code Chapters 1272 or 1305 or the Labor Code Chapters 407 or 407A and rules adopted thereunder. New §7.1601(d) clarifies that the new subchapter does not apply to a person acting as or holding itself out as an administrator for an ERISA qualified employee welfare benefit plan that is exempt from regulation by this state with respect to that particular employee welfare benefit plan.

§7.1602. Definitions. Adopted new §7.1602 defines the terms used in the adopted new subchapter.

§7.1603. Certificate of Authority Required. Adopted new §7.1603(a) requires each person acting as or holding itself out as an administrator to hold a certificate of authority under the Insurance Code Chapter 4151, unless the person meets an exemption under that chapter. New §7.1603(b) requires an administrator contractor and an administrator subcontractor to hold a certificate of authority under the Insurance Code Chapter 4151.

§7.1604. Application for Certificate of Authority. Adopted new §7.1604(a) requires an applicant for a certificate of authority under Chapter 4151 to file an application with the Department, accompanied by a non-refundable fee of $1,000. New §7.1604(a) also requires the applicant to verify the application by attesting to the truth and accuracy of the information in the application. New §7.1604(b)(1) adopts by reference the following forms, which comprise the application for a certificate of authority under the Insurance Code Chapter 4151. These forms are available at www.tdi.state.tx.us/forms/form5tpa.html: (i) Form Number FIN 489, Application for a Certificate of Authority; (ii) Form Number FIN 306, Officers and Directors; (iii) Form Number LHL 081, Biographical Affidavit; and (iv) Form Number LHL 082, Service of Process. New §7.1604(b)(2) specifies that as authorized by the Insurance Code §4151.206(a)(1), the Commissioner adopts a filing fee of $1,000 to be paid by an applicant for processing an original application for a certificate of authority for an administrator. Adopted new §7.1604(c) requires an applicant to register its official name with the Department and the Office of the Secretary of State, as applicable. Additionally, new §7.1604(c) specifies that an applicant must register an alternative name with the Department and the Office of the Secretary of State, as applicable, if the Commissioner determines that an applicant's name is too similar to a name already registered with the Department. Adopted new §7.1604(d)(1) requires each executive officer or other comparable responsible person of an applicant to provide the Department with a completed Form Number LHL 081, Biographical Affidavit. New §7.1604(d)(1) also specifies that a biographical affidavit is not required if a biographical affidavit from the individual has been filed with the Department within the prior three years and contains substantially accurate information. Further, new §7.1604(d)(1) clarifies that a biographical affidavit contains substantially accurate information if the responses given by the individual in the affidavit on file with the Department continue to indicate sufficient experience, ability, standing, and good record to make success of the applicant probable. Adopted new §7.1604(d)(2) requires each person filing a biographical affidavit under new §7.1604(d)(1) to comply with the requirements of Chapter 1, Subchapter D of Title 28 of the Texas Administrative Code. Pursuant to the Insurance Code §4151.052(a)(5), new §7.1604(e) provides that the Commissioner may require the submission of any other information the Commissioner reasonably requires in determining whether to approve or disapprove an application for a certificate of authority.

§7.1605. Notification Requirements. Adopted new §7.1605(a) specifies that an insurer or HMO that is acting as or holding itself out as an administrator and that is not exempt under the Insurance Code §4151.002(3) or (4) is subject to all provisions of the new subchapter, except adopted new §§7.1603, 7.1604, and 7.1609(c) and (d)(1) and (2) (relating to Certificate of Authority Required, Application for Certificate of Authority, and Annual Report). Adopted new §7.1605(b) requires an insurer or HMO meeting the requirements of new §7.1605(a) to submit written notice to the Department that it will be acting as or holding itself out as an administrator. New §7.1605(b) further requires such notice to include the insurer's or HMO's contact information. This includes: (i) the insurer's or HMO's TDI company number; (ii) a narrative describing the insurer's or HMO's facilities, personnel, and experience relating to the functions the insurer or HMO will be performing as an administrator; and (iii) a list of any other states in which the insurer or HMO will be acting as or holding itself out as an administrator.

§7.1606. Requirements Related to Ownership Interest and Change of Control. The provisions of adopted new §7.1606(a)(1) - (3) relate to a change in the control of an applicant or administrator. The three provisions are for purposes of new §7.1606 only and for no other purposes. Adopted new §7.1606(a)(1) provides that control means the power to direct, or cause the direction of, the management and policies of a person, other than the power that results from an official position with or corporate office held by the person. Adopted new §7.1606(a)(2) provides that control may be possessed by various means, including through ownership of voting securities, ownership by contract, or direct or indirect control of one or more persons that control an administrator. Adopted new §7.1606(a)(3) provides that control exists if an individual or a member of an individual's immediate family, directly or indirectly, owns, controls, or holds with the power to vote 10 percent or more of the voting securities or authority of an administrator or another person that directly or indirectly controls an administrator, including when a person holds proxies representing 10 percent or more of the voting securities or authority of the person. Pursuant to the Insurance Code §4151.052(b), adopted new §7.1606(b) requires an applicant or an administrator to notify the Department in writing of a change of control in the ownership of the applicant or the administrator not later than the 30th day after the effective date of the change. The §7.1606(b) notice requirement applies to any instance in which there is a change in the control of an applicant or administrator, including a change in any of the circumstances specified in §7.1606(a). Adopted new §7.1606(c) provides that an applicant or administrator may not file the §7.1606(b) notification until a proposed acquisition of control has been approved under the Insurance Code §4151.211.

§7.1607. Facts and Circumstances Affecting Issuance of Certificate of Authority. Adopted new §7.1607(a) defines the phrase "material change in fact or circumstance." The phrase is defined as any fact or circumstance that impacts the accuracy or completeness of the information filed in an applicant's or administrator's initial application for a certificate of authority under the Insurance Code Chapter 4151. It includes: (i) a change in an applicant's or administrator's mailing address; (ii) a felony conviction of any executive officer or other comparable responsible

person of an applicant or administrator or of any other person who directly or indirectly controls the applicant or administrator; and (iii) any administrative action, order, or judgment issued against an applicant or administrator. Adopted new §7.1607(b) requires an administrator to notify the Department in writing of a material change in fact or circumstance not later than the 30th day from the date the administrator first becomes aware of the material change in fact or circumstance. Except as provided by new §7.1606(b) (relating to Requirements Related to Ownership Interest and Change of Control), new §7.1607(c) requires an applicant to continually update the information filed in its initial application for a certificate of authority under the Insurance Code Chapter 4151 while the application is pending with the Department. This includes notifying the Department in writing of a material change in fact or circumstance. Adopted new §7.1607(d) requires an applicant or administrator to meet the requirements of the Insurance Code Chapter 4151 and the new subchapter as those requirements apply to any material change of fact or circumstance identified by an administrator or any change in information identified by an applicant. Finally, new §7.1607(e) requires an applicant or an administrator to maintain the qualifications necessary to obtain a certificate of authority under Chapter 4151 at all times.

§7.1608. Fidelity Bond. Adopted new §7.1608(a) requires an applicant to obtain and an administrator to maintain a fidelity bond that complies with the requirements of the Insurance Code §4151.055 and new §7.1608. Adopted §7.1608(b) specifies that an applicant and an administrator may only obtain a fidelity bond from a surety company authorized to engage in business in this state as a surety or an eligible surplus lines insurer in compliance with the Insurance Code Chapter 981 and rules adopted thereunder. Adopted new §7.1608(c) requires an applicant or an administrator to immediately inform the Commissioner in writing if its fidelity bond is cancelled or terminated and not replaced with new coverage. The new coverage must meet the requirements of the Insurance Code §4151.055 and new §7.1608 and be effective concurrently upon the date of the cancellation or termination. Finally, adopted new §7.1608(c) specifies that the required notification to the Commissioner must be given no later than ten business days from the date the applicant or the administrator first becomes aware of the cancellation or termination.

§7.1609. Annual Report. Adopted new §7.1609(a) requires an administrator to file an annual report with the Department no later than June 30 each year, accompanied by a non-refundable fee of $200. Adopted new §7.1609(b) adopts by reference the following forms: (i) Form Number FIN 486, Annual Report Form for Administrators Holding a Certificate of Authority under TIC 4151; (ii) Form Number FIN 487, Annual Report Form for Insurers and HMOs Subject to 28 TAC §7.1605; (iii) Form Number FIN 488, Annual Report Exhibits A-E; and (iv) Form Number 490, Certification of Financial Statement. These forms are available at www.tdi.state.tx.us/forms/form5tpa.html. Adopted new §7.1609(c) specifies that the annual report required by new §7.1609(a) must also include an audit report on the financial statements prepared by an independent certified public accountant that reflects an audit conducted in accordance with generally accepted auditing standards or with the standards adopted by the Public Company Accounting Oversight Board, as applicable. It must also include a balance sheet, an income statement, a cash flow statement, and a statement of equity. Adopted new §7.1609(d)(1) exempts an administrator receiving less than $10 million in compensation for providing administrative services in Texas during the preceding year from complying with the requirements of new §7.1609(c) for that year. Adopted new §7.1609(d)(2) requires an administrator qualifying for the exemption in §7.1609(d)(1) to file a financial statement with the Department that: (i) includes a completed Form Number FIN 490, Certification of Financial Statement, as referenced in §7.1609(b)(1)(D); and (ii) is verified by at least two officers or other comparable responsible persons of the administrator. Adopted new §7.1609(d)(3) clarifies that an administrator qualifying for the exemption in new §7.1609(d)(1) must still meet the other requirements of new §7.1609. Adopted new §7.1609(e) provides that the Commissioner may request additional information as necessary to determine if an administrator is operating or conducting business in a hazardous or injurious manner.

§7.1610. Financial Statements Under the Education Code. Adopted new §7.1610(a) provides that §7.1610 applies only to an insurer or HMO that: (i) meets the requirements of §7.1605 (relating to Notification Requirements) of this subchapter; and (ii) is subject to the requirements of the Education Code §22.004(g). Adopted new §7.1610(b) provides that an administrator meeting the requirements of §7.1610(a) may comply with the requirement for an audited financial statement under the Education Code §22.004(h) by providing a copy of the financial statement filed with the Department for the preceding calendar year that: (i) was prepared by an independent certified public accountant; and (ii) was filed in compliance with the requirements of §7.18 (relating to the National Association of Insurance Commissioners Accounting Practices and Procedures Manual) and §7.85 (relating to Audited Financial Reports).

§7.1611. Operational Review and On-Site Audit. Adopted new §7.1611(a) requires an insurer, no less than two times each fiscal year, to review the operations of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders. New §7.1611(a) also provides that a review of an administrator may be conducted on the premises of the insurer or at another location designated by the insurer. The review may also be conducted by electronic means. Adopted new §7.1611(b) requires an insurer, no less than once every two fiscal years, to conduct an on-site audit of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders. Adopted new §7.1611(c) specifies that, notwithstanding the requirements of new §7.1611(a), an insurer is not required to review the operations of an administrator under new §7.1611(a) more than one time in the same fiscal year in which the insurer conducts an on-site audit of that administrator. Adopted new §7.1611(d) specifies that any review and on-site audit must assess the business practices and procedures of the administrator to ensure competent administration, including evaluating: (i) the administrator's compliance with the Insurance Code, the Labor Code, and rules adopted thereunder, as applicable; (ii) the administrator's compliance with the provisions of the written agreement with the insurer; (iii) the administrator's performance of claims adjudication and payment; (iv) the adequacy of the financial security maintained by the administrator, if any; and (v) the administrator's practices and procedures for establishing the adequacy of the insurer's reserves, if any. Adopted new §7.1611(d) also specifies that any review and on-site audit must include a written summary of the objectives and scope of the review or on-site audit and the results of the review or on-site audit. It must also include a corrective action plan addressing any deficiencies found during the review or on-site audit. Adopted new

§7.1611(e) specifies that the purpose of the on-site audit is to verify the accuracy, integrity, and completeness of the information received during a review conducted by an insurer pursuant to new §7.1611(a). Adopted new §7.1611(e) also requires that an on-site audit include: (i) a physical inspection of the administrator's place of business; and (ii) a written assessment of the reliability of the information provided to the insurer and relied upon by the insurer when conducting a review or on-site audit of the administrator. Adopted new §7.1611(f) authorizes an insurer or the insurer's designated representative to perform a review or an on-site audit. Adopted new §7.1611(g) permits an insurer to meet the requirements of new §7.1611 for an administrator subcontractor by reviewing and auditing only the administrator contractor if two specified conditions are met: (i) the information supplied to the insurer by the administrator contractor includes all necessary and relevant information relating to the administrator subcontractor; and (ii) provided no evidence of material non-compliance by the administrator subcontractor exists. Adopted new §7.1611(h) requires all information and documentation related to a review or an on-site audit to remain on file with the insurer for at least five years from the date of the review or on-site audit and to be made available to the Commissioner upon request.

§7.1612. Fiduciary Bank Accounts. Pursuant to the Insurance Code §4151.106(b), adopted new §7.1612(a) requires an administrator to hold all premium in a fiduciary capacity. Adopted new §7.1612(b) requires an administrator collecting or receiving any premium to comply with the Insurance Code §§4151.105, 4151.106, 4151.107, and 4151.108 and adopted new §7.1612. New §7.1612(b) also requires each administrator who receives any premium on behalf of an insurer, HMO, plan sponsor, or group to report the receipt of that premium to the insurer, HMO, plan sponsor, or group within a reasonable amount of time. Adopted new §7.1612(c) requires an administrator to establish at least one fiduciary bank account to hold any premium collected or received pursuant to new §7.1612. Adopted new §7.1612(d) requires a fiduciary bank account required by adopted new §7.1612(c) to be established and styled as an escrow account. Adopted new §7.1612(e) requires an administrator to maintain each fiduciary bank account at a financial institution that is: (i) organized under the laws of the United States or any state thereof; and (ii) regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies. Additionally, new §7.1612(e) specifies that a fiduciary bank account may only consist of one or more of the following types of investments: (i) cash and cash equivalents, including savings accounts, checking accounts, money market accounts, and certificates of deposit; (ii) non-assessable money market mutual funds that are primarily invested in United States government securities; and (iii) other investments of substantially similar quality, as approved by the Commissioner. Adopted new §7.1612(f) requires an administrator to maintain detailed accounting records for each fiduciary bank account that separately record each deposit and withdrawal from the account. The accounting records must identify each insurer, HMO, plan sponsor, or group for whom the account is maintained. Adopted new §7.1612(g) requires that, upon the reasonable request of the insurer, HMO, plan sponsor, or group, an administrator must provide an insurer, HMO, plan sponsor, or group a copy of all records relating to the requesting entity's account activity in a fiduciary bank account established or maintained by the administrator on behalf of the insurer, HMO, plan sponsor, or group. Adopted new §7.1612(h) provides that all records maintained by an administrator relating to any premium shall be subject to examination by the Commissioner upon request. Pursuant to the Insurance Code §4151.109, adopted new §7.1612(i) prohibits an administrator from paying a claim from a fiduciary bank account. Finally, adopted new §7.1612(j) provides that new §7.1612 does not authorize any transaction that is otherwise prohibited by law.

§7.1613. Written Agreements Between Administrators and Insurers. Adopted new §7.1613(a) prohibits an administrator from providing administrative services in Texas on behalf of an insurer unless the administrator has entered into a written agreement with the insurer that meets the requirements of the Insurance Code Chapter 4151 and adopted new §7.1613. Adopted new §7.1613(b) permits an administrator subcontractor to meet the requirements of new §7.1613 by entering into a written agreement with the administrator contractor only. Section 7.1613(b) also requires that the written agreement meet the requirements of the Insurance Code Chapter 4151 and new §7.1613, as applicable. Adopted new §7.1613(c) prohibits a written agreement entered into under new §7.1613 from being construed to limit, in any way, an insurer's ultimate accountability and responsibility for compliance with all statutory and regulatory requirements under the Insurance Code, the Labor Code, and rules adopted thereunder. Adopted new §7.1613(d) specifies the requirements for a written agreement entered into under new §7.1613. to include: (i) a requirement that an administrator comply with all statutory, contractual, and regulatory requirements related to a function assumed or carried out by the administrator and related to a plan for which the administrator performs or offers to perform administrative services; (ii) a description of the administrative services the administrator is expected to provide and any applicable instructions related to the performance of those services, including references to an insurer's claims handling practices or procedures; (iii) a provision relating to the continuity of services and addressing the obligations of the administrator and the insurer under adopted new §7.1615 (relating to Transfer of Books and Records), including the method and manner in which the insurer and administrator will meet those requirements; and (iv) a provision addressing an insurer's obligation to review and audit the performance of its administrators under adopted new §7.1611 (relating to Operational Review and On-Site Audit), including the method and manner in which the insurer will meet those requirements. Adopted new §7.1613(e) also requires a written agreement entered into under new §7.1613 to ensure that the books and records of the insurer remain the property of the insurer at all times and that the books and records of the insurer are available to the insurer or its designee at any time while in the custody of the administrator. Adopted new §7.1613(f), however, permits an administrator to retain a proprietary interest in the books and records of an insurer pursuant to the Insurance Code §4151.113(c) under one condition. Retention of a proprietary interest requires that the written agreement between the administrator and the insurer must specifically identify the items that will be subject to the administrator's proprietary interest. Further, new §7.1613(f) prohibits an administrator from withholding, based upon a claim of proprietary interest, any portion of an insurer's books and records that would restrict the ability of the insurer to comply with statutory, regulatory, or contractual obligations. Adopted new §7.1613(g) permits a master services agreement to be used to meet the §7.1613 requirements. Adopted new §7.1613(h) permits any §7.1613 requirement that does not apply to an administrative service offered or performed by the administrator on behalf of the insurer to be omitted from the written agreement between the administrator and the insurer. New §7.1613(h) also requires the remainder of the written agreement

between the administrator and the insurer to comply with the Insurance Code Chapter 4151 and new §7.1613. Finally, adopted new §7.1613(i) requires a written agreement to meet the requirements of new §7.1613 no later than September 1, 2009.

§7.1614. Prohibited Acts. Adopted new §7.1614(a) prohibits an administrator from: (i) misrepresenting the terms or nature of an agreement with an insurer, HMO, plan sponsor, or group; (ii) making false, misleading, or incomplete comparisons to the agreements of other administrators or persons in order to induce any person to enter into, continue, or discontinue an agreement; (iii) accepting or rejecting risk, other than under the authority of, and in accordance with, a written agreement with an insurer, HMO, plan sponsor, or group; (iv) publishing or circulating any advertising or informational material, benefit descriptions, certificates, booklets, or brochures pertaining to business underwritten by an insurer, HMO, plan sponsor, or group without advance written approval of the insurer, HMO, plan sponsor, or group; (v) pursuant to the Labor Code §415.0036, offering to pay, paying, soliciting, or receiving an improper inducement relating to the delivery of benefits to an injured employee, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state; and (vi) pursuant to the Labor Code §415.0036, improperly attempting to influence the delivery of benefits to an injured employee, including through the making of improper threats, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state. Adopted new §7.1614(b) provides that an administrator may be subject to other prohibitions under the Insurance Code, the Labor Code, and rules adopted thereunder that are not specified in adopted new §7.1614(a).

§7.1615. Transfer of Books and Records. Adopted new §7.1615(a) requires an administrator to provide books and records to a successor administrator no later than 30 days from the date of the termination of the relationship or written agreement with an insurer, HMO, plan sponsor, or group, unless otherwise provided by the Commissioner. If there is not a successor administrator, or if the successor administrator is unknown at the time of the required transfer, the set or copy of the books and records must be provided to the insurer, HMO, plan sponsor, or group. The books and records must be provided to a successor administrator or to the insurer, HMO, plan sponsor, or group either as a complete and accurate original set or a complete and accurate copy or image of the original set of an insurer's, HMO's, plan sponsor's, or group's books and records. Adopted new §7.1615(b) requires the books and records to be transferred in an organized and usable manner. Adopted new §7.1615(c) requires the allocation of the payment of costs associated with providing the insurer's books and records to be addressed in the written agreement between the insurer and the administrator. Adopted new §7.1615(d) requires an administrator to provide written notice to the Department of the termination of a relationship or written agreement with an insurer, HMO, plan sponsor, or group no later than thirty days from the date the administrator first learns of the termination. Adopted new §7.1615(e) permits an administrator subcontractor to meet the requirements of new §7.1615 when its relationship or written agreement with an administrator contractor terminates by providing a complete and accurate original set or a complete and accurate copy or image of the original set of the insurer's, HMO's, plan sponsor's, or group's books and records to the administrator contractor. The administrator subcontractor must also provide written notice to the Department of the termination of the relationship or written agreement with the administrator contractor no later than thirty days from the date the administrator subcontractor first learns of the termination.

§7.1616. Hazardous or Injurious Operating Conditions. Adopted new §7.1616(a) provides that an applicant or an administrator may be considered to be operating or conducting business in a hazardous or injurious manner if the administrator or applicant: (i) has failed to file financial statements, documents, records, or reports required under the Insurance Code Chapter 4151 or the new subchapter within the time periods prescribed by the Insurance Code Chapter 4151, the new subchapter, or as requested by the Department pursuant to law; (ii) has filed any false or misleading financial information; (iii) is unable to pay its obligations as they become due and payable; (iv) has not maintained records sufficient to permit examiners to determine its financial condition or compliance with the Insurance Code, the Labor Code, and rules adopted thereunder; (v) does not employ management staff with the experience, competence, or trustworthiness to conduct its operations in a safe or sound manner; (vi) employs management staff that has engaged in any unlawful activity; (vii) has not complied or is not complying with the terms of a written agreement with an insurer, HMO, plan sponsor, or group; (viii) has engaged or is engaging in a pattern of failing to settle claims in accordance with contractual, regulatory, or statutory requirements; or (ix) has engaged or is engaging in fraudulent or dishonest practices or acts. Adopted new §7.1616(b) provides that other facts and circumstances not specified in new §7.1616(a), as determined by the Commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state, may also indicate that an applicant or administrator is operating in a hazardous or injurious manner.

§7.1617. Examinations. New §7.1617(a) adopts a non-refundable fee of $500 for the expenses of an examination conducted under the Insurance Code §4151.201. New §7.1617(b) provides that, prior to an examiner entering the property of an administrator, written notice must be given to the administrator. The written notice must include the date and estimated time the examiner will enter the property of the administrator.

§7.1618. Severability. Adopted new §7.1618 provides that if any section or portion of a section of the new subchapter is held to be invalid for any reason, all valid parts are severable from the invalid parts and remain in effect. Further, new §7.1618 provides that if any section or portion of a section of the new subchapter is held to be invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications. Finally, new §7.1618 provides that all provisions of the new subchapter are severable.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Dual Regulation, Duplicative Requirements, and Inconsistency with Legislative Intent

Comment: One commenter objects to the proposed rules because they may result in dual regulation for individuals and entities or subject them to regulation that creates an unreasonable burden that is inconsistent with the legislative intent of HB 472. A second commenter requests that the Department remove all unnecessary duplication of existing statutory or regulatory requirements under the Insurance Code or the Labor Code for administrators. Another commenter contends that without a definition of "administrator" that clarifies what it means to "adjust" or settle" a claim, the range of "persons" that will be required un-

der these rules to obtain a certificate of authority is extremely broad and requests clarification on whether independent adjusting firms or other ancillary service providers are "administrators" under Chapter 4151. According to the first commenter, the intent of the Texas Legislature when it passed HB 472 was to provide for the regulation of administrators who are responsible for the day-to-day overall management authority over money and claims. The commenter states that the proposed rules raise questions about the intent of Department staff with regard to the regulation of administrators and other entities or individuals who provide specific services to either an insurance company or the insurer's administrator and do not adjust or settle claims. The commenter states that the rules should not treat or classify entities or individuals who provide specific services to a self-insured group, the self-insured group's third-party administrator, or an insurers' third-party administrator who does not collect premiums or contributions from a self-insurance group or adjust or settle claims as an administrator for the purposes of the Insurance Code Chapter 4151. The commenter recommends that the Department clarify the rules to provide that the certificate of authority requirement is limited to an entity that actually adjusts or settles claims. This commenter further objects to the proposed rules because the commenter contends that they may subject persons or entities to dual regulation and dual reporting requirements not contemplated by the Texas Legislature that would result in an unfair, unreasonable, and overly burdensome regulatory scheme that is not appropriate to implement Chapter 4151 of the Insurance Code. Before inquiring about 19 individuals and entities that the commenter believes should not be subject to the administrator requirements in Chapter 4151 of the Insurance Code and these rules, the commenter reiterates the provisions of §4151.002 of the Insurance Code that exempts certain individuals and entities from regulation as administrators: (i) a person who provides technical, advisory, utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor but does not make any management or discretionary decisions on behalf of the insurer, plan, or plan sponsor; and (ii) a person who adjusts or settles claims in the normal course of the person's practice or employment as a licensed attorney and who does not collect any premium or charge in connection with annuities or workers' compensation benefits. This commenter then lists examples of 19 individuals or entities that contract with, or whose services are used by, self-insurance groups, insurers, and third party administrators. These 19 individuals and entities are (1) attorneys and law firms who provide legal advice and representation in the dispute resolution proceedings managed and conducted by the Division of Workers' Compensation (DWC) and for issues related with the DWC's and the Department's enforcement process; (2) utilization review agents (URA) that handle both prospective and retrospective utilization review, the URA is certified by the Department pursuant to the workers' compensation utilization review rules, Rules 19.2001 - 19.2021; (3) utilization review agents that review medical bills that must be paid by the self-insurance group or a third-party administrator (TPA); the self-insurance group's TPA and TPAs for insurers that have the ultimate decision-making authority as to whether or not to pay medical bills; (4) case management companies and/or individual case managers that provide consultative and technical services that includes assisting with the case management of different aspects of a claim, e.g. return-to-work, coordination of work status assessment, coordination of appropriate treatment for an injured employee, job site analysis, ergonomic assessments, occupational case management, assessment of maximum medical improvement status, vocational rehabilitation, and management of catastrophic injury cases; (5) actuarial firms that provide consultative services that includes providing statements of actuarial opinion, account audit support, rate-making actuarial services, underwriting audit services, and other actuarial services; (6) EDI trading partner/agents who provide electronic data interchange technical services, software and/or submit claims payment and medical bill payment data to the DWC; (7) safety consultants who provide consultation to self-insured groups (SIG), SIG TPAs and TPAs of insurers for the purpose of improving workplace safety and loss control; (8) peer review doctors who provide prospective, concurrent, and retrospective utilization review services for the purpose of ascertaining the appropriateness of future, on-going, or past healthcare and to address other medical issues related to a specific claim; (9) eBill agents who provide technical services to self-insurance groups for the payment of medical bills electronically transmitted for payment under the provisions of DWC rules 28 TAC §133.500 and §133.50; (10) certified workers' compensation health care networks contracted with by self-insurance groups as provided for by Chapter 1305 of the Insurance Code and the Department's Chapter 10 Certified Workers' Compensation Healthcare Network Rules; (11) DWC-appointed designated doctors requested by the TPA for the purpose of obtaining a recommendation about an injured employee's medical condition, to resolve a dispute about an injured employee's work-related injury or occupational illness, or to resolve a dispute regarding the work status and/or impairment rating of an injured employee; the designated doctor process is regulated by the DWC's Chapter 126 rules; (12) required medical examiners (doctors) selected by the TPA for the purpose of obtaining an opinion on the appropriateness of the health care received by employees; required medical examiners are regulated by the DWC's Chapter 126 rules; (13) private investigators or private investigation firms to obtain special investigation unit services associated with the investigation of suspected insurance fraud or to obtain surveillance of injured employees who are suspected of having filed fraudulent claims or exaggerated the extent of the injury and disability; (14) independent adjusters who are licensed adjusters not on the staff of an insurance carrier or self-insured and do not adjust or settle a claim but rather investigate accident sites and obtain statements from injured employees, employers, accident witnesses, treating doctors, and perform related services, e.g. attending a DWC benefit review conference, contested case hearing, and submitting medical dispute resolution responses to the Division of Workers Compensation, and so forth as provided for by §4151.002(13) of the Insurance Code; (15) workers' compensation Austin representatives required by §156.1 of the Labor Code who act, by law, as the insurer's or self-insured group's representative to the DWC and agent for receiving notices, decisions, and orders from the DWC; (16) accident reconstruction experts who provide a technical service that assists in the investigation of a claim by an insurer, self-insurance group or a third-party administrator; (17) home modification contractors who provide a technical service to insurers, self-insurance group or a third-party administrator and complete modification construction projects that allows disabled injured employees to have better access to their workplaces, work stations, and homes; (18) medical set aside vendors who provide a technical service that provides for Medicare set-aside for the workers' compensation insurers, self-insurance groups, and third-party administrators; and (19) independent claims auditing firms that provide technical and consultative services to insurers, self-insured groups, and third-party administrators and audit their respective claims for compliance and accuracy of payment of claims. According to the commenter, (i) none of these

19 individuals and entities collects premiums or contributions or adjusts or settles claims on behalf of a self-insurance group or insurer; (ii) each of these individuals and entities provides services to a self-insurance group and/or a TPA that are advisory or technical in nature and do not constitute the adjusting or settling of a claim; (iii) when contracting with one of these 19 persons or entities, the self-insurance group, a SIG's TPA, insurer and a TPA retains the decision-making authority for resolving disputed claims issues in benefit disputes, determining whether or not a medical bill is to be paid or denied, determining whether or not health care presented for pre-authorization is approved pursuant to the provisions of DWC Rule 134.600; (iv) the Labor Code and associated rules adopted by the Commissioner of Workers' Compensation regulate these activities and provide for enforcement of the associated rules; (v) the insurer or self-insured group is responsible for any violation of DWC rules as they relate to payment of benefits; and (vi) legislative offices have routinely reinforced this concept when weighing in on rules proposed by the DWC. The commenter further contends that the language in proposed §7.1601(c) appears to indicate that the Department expects certified workers' compensation health care networks to have to obtain a certificate of authority in addition to that already granted by the Department under the Chapter 10 Certified Workers' Compensation Healthcare Network Rules. According to the commenter, the Commissioner does not have the statutory authority to adopt rules that would result in the dual regulation of these persons. The commenter further asserts that HB 472 requires the rules adopted by the Commissioner to be fair, reasonable, and appropriate to augment and implement the Insurance Code §4151.006. The commenter recommends that the Department: (i) clarify proposed §7.1601(a) and (c) to provide that certified workers' compensation health care networks will not be required to obtain certificates of authority under the Insurance Code §4151 and §§7.1601 - 7.1618 and will not be subject to dual data reporting requirements since they are already required to obtain certificates to operate as workers' compensation health care networks under the Insurance Code Chapter 1305 and the Department's Chapter 10 rules concerning workers' compensation health care networks; (ii) clarify proposed §7.1601(a) to recognize the provisions of the Insurance Code §4151.002 and the fact that §4151.002 identifies specific individuals and entities that are exempted from the provisions of the Insurance Code Chapter 4151 as it applies to the regulation of administrators; (iii) conduct a Department review of the current data reporting requirements of certified workers' compensation networks to ascertain the data currently submitted by certified workers' compensation networks pursuant to the provisions of the Department's Chapter 10 rules; (iv) clarify in the rule adoption preamble that a certified workers' compensation network would only have to obtain a certificate of authority under the Insurance Code §4151.001(1) should they contract with an insurer or self-insured to perform the duties of an administrator; (v) revise the rules to specifically exempt the 19 entities or individuals listed by the commenter from the administrator certificate of authority requirement as provided in the Insurance Code §4151.002; and (vi) revise the proposed rules in a manner that would not extend the regulatory scheme and the requirement to obtain an administrator certificate of authority to those individuals or entities that do not perform duties of a third-party administrator. The second commenter, in objecting to the duplicative statutory and regulatory requirements, asserts that this examination of existing requirements could reduce costs and eliminate administrative burdens that could ultimately result in savings to policyholders. The commenter further states that while it understands that the Department has made explicitly clear in the rule proposal that duplicative registration and licensing requirements may apply (e.g., proposed new §7.1601(a) and page 4 of 158 in the preamble section), the commenter respectively submits that this duplication is moving in the wrong direction. According to the third commenter, reasonable people may disagree on the merits of the arguments about whether so-called "independent adjusting firms" or other ancillary service providers should be considered "administrators" under Chapter 4151. The commenter states that the rules and Chapter 4151 are not clear on whether the following entities or persons are "administrators" under Chapter 4151: (i) private investigation companies that perform investigations in workers' compensation claims; (ii) independent adjusters, and the firms they work for, that perform limited assignments on behalf of insurers, such as taking a statement of a witness, claimant, or employer, obtaining medical records from a doctor or hospital, preparing and filing compensability disputes or requests for designated doctor appointments, etc.; (iii) Austin representatives designated by insurance carriers pursuant to the Labor Code §406.011 and §156.1 of this title that pick up and transmit mail between the DWC and their clients, request record checks and obtain records on prior claims from the DWC, review or propose dispute language to their clients, consult with their clients on whether a claim is compensable, or attend hearings on behalf of clients. The commenter further inquires at what point does the activities of Austin representatives cross the line and become "adjusting" or "settling" claims as those terms are used in the Insurance Code §4151.001.

Agency Response: The Department disagrees with all of the commenter's recommended changes for the following reasons. The intent of the rules, consistent with the intent of Chapter 4151 as enacted by HB 472, is to regulate administrators in accordance with the Insurance Code Chapter 4151. The Department disagrees that the proposed rules as adopted will subject persons to dual regulation and dual reporting requirements for performing the functions authorized under a single statutory authorization, or result in a regulatory scheme that is unfair, unreasonable, overly burdensome, or inappropriate for implementing the Insurance Code Chapter 4151. This includes the 22 individuals and entities inquired about by two commenters, who, because of the definition of "administrator" in the Insurance Code §4151.001(1) and the statutory exemptions specified in the Insurance Code §4151.002 and §4151.0021, may or may not be subject to the rules and Chapter 4151 of the Insurance Code. The Department further disagrees that the adopted rules require all certified workers' compensation health care networks to obtain a certificate of authority under the Insurance Code Chapter 4151 to act as an administrator or that the rules as adopted need to be clarified to specifically exempt from regulation under the Insurance Code Chapter 4151 the individuals or entities listed by the two commenters. First, the Department believes that these rules clearly, fairly, reasonably, and appropriately implement and augment the Insurance Code Chapter 4151. The rules, which are consistent with the regulatory scheme under Chapter 4151, treat or classify entities and individuals who act as or hold themselves out as administrators in accordance with the Insurance Code Chapter 4151. Section 7.1601 specifies who the rules apply to and provides that a person acting as or holding itself out as an administrator must meet the requirements of the Insurance Code Chapter 4151 and this subchapter in addition to any other requirements applicable to that person under the Insurance Code Chapters 1272 or 1305 or the Labor Code Chapters 407 or 407A and any rules adopted thereunder except as otherwise provided by statute or rule. Section 7.1603 provides

that any person acting as or holding itself out as an administrator, administrator contractor, or administrator subcontractor must hold a certificate of authority under the Insurance Code Chapter 4151--unless a person meets an exemption under the Insurance Code §§4151.002, 4151.0021, or 4151.004. Sections 7.1601 and 7.1603 are consistent with the provisions of the Insurance Code §4151.051(a), which prohibit "[a]n individual, corporation, organization, trust, partnership, or other legal entity" from acting as or holding itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under Chapter 4151. Thus, by its plain language, the Insurance Code §4151.051(a) requires not only persons that act as administrators to obtain certificates of authority but also persons that hold themselves out as administrators. It is clear from this plain language that the intent is not to regulate as administrators only those persons that actually adjust or settle claims or only those administrators who are responsible for the day-to-day overall management authority over money and claims, but also those persons that hold themselves out as administrators, as contemplated under §4151.051(a). The following scenario is offered for illustrative purposes. The scenario assumes that a person that does not meet any of the exemptions in the Insurance Code Chapter 4151 enters into a contract with an insurer, which delegates to this person the authority to adjust or settle a claim on behalf of the insurer. This person never actually performs the function of adjusting or settling a claim on behalf of the insurer. Under this scenario, the person is holding itself out as an administrator, as contemplated under the Insurance Code §4151.051(a), despite the fact that the person never actually adjusts or settles a claim on behalf of the insurer. None of the Chapter 4151 provisions limit the certificate of authority requirement in §4151.051(a) in the manner requested by one commenter, i.e., that only a person that is responsible for the day-to-day overall management authority over money and claims is required to obtain a certificate of authority. Therefore, these rules cannot provide that only a person that is responsible for the day-to-day overall management authority over money and claims is required to obtain a certificate of authority.

Additionally, §7.1601 and §7.1603 as adopted clearly and appropriately incorporate the definitions of "administrator," "administrator contractor," and "administrator subcontractor" in §7.1602(1), (3), and (4) respectively. Sections 7.1602(1), (3), and (4) as adopted, in turn, clearly and appropriately incorporate and are consistent with the statutory definition of the term *administrator* that is in the Insurance Code §4151.001(1) in combination with the other provisions of Chapter 4151, including the exemptions specified in §4151.002 and §4151.0021. The definitions in §7.1602(1), (3), and (4) explicitly incorporate the definition of administrator in the Insurance Code §4151.001(1) and the exemptions enumerated in §4151.002 and §4151.0021. Section 4151.001(1) defines an *administrator* as a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Further, §4151.001(1) provides that the term does not include a person described by §4151.002, but provides that the term includes: (i) a delegated entity under the Insurance Code Chapter 1272; and (ii) a workers' compensation health care network authorized under the Insurance Code Chapter 1305 that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. Section 7.1602(1) also provides that the term "administrator" includes administrator contractors and administrator subcontractors. This provision is based on the Insurance Code §§4151.001(1), 4151.002, 4151.0021, and 4151.051(a), which provide that regardless of a person's position in a contractual relationship, whether as a direct contractor or down-stream subcontractor, a person is an administrator for purposes of Chapter 4151 and the rules if that person performs or offers to perform a function as an administrator as defined in §4151.001(1), and that person does not meet an exemption described in §4151.002 or §4151.0021. For clarity, the definitions in §7.1602(3) and (4) for the terms "administrator contractor" and "administrator subcontractor" reiterate these two exemptions. Thus, in order to determine whether a person is an *administrator* as defined in adopted §7.1602(1) or as that term is used in the adopted rules, including §7.1601 and §7.1603, it is necessary to evaluate the functions or services that the person is performing or providing, or offering to perform or provide and whether the person is specifically exempted from any of the requirements of the Insurance Code Chapter 4151. Whether a particular person qualifies as an "administrator" or meets an exemption under Chapter 4151 and the adopted rules is a case-by-case, fact-specific determination. Therefore, each of the individuals and entities that the two commenters inquired about would be subject to this case-by-case, fact-specific determination to ascertain whether each of these persons qualifies as an "administrator" and is therefore, subject to regulation under Chapter 4151 and these rules. Pursuant to the Labor Code Chapter 407A, the Insurance Code Chapter 4151 and the §7.1601 and §7.1603 rules, if the person qualifies for a specific exemption in the Insurance Code §4151.002 or §4151.0021, the person is not an administrator for the purpose of these rules. However, if the person does not qualify for one of these exemptions, and the person collects or offers to collect premiums or contributions from residents of this state or adjusts, settles, or offers to adjust or settle claims for residents of this state, in connection with annuities or life, health, accident, pharmacy, or workers' compensation benefits, the person meets the definition of *administrator* in the Insurance Code §4151.001(1) and new §7.1602(1). This is true, regardless of whether the person is also performing or providing other functions or services that subject the person to compliance with the Insurance Code and the Labor Code. Thus, if a person is performing any act that is the act of an administrator under Chapter 4151 of the Insurance Code or under these rules or is holding itself out as an administrator under §4151.051(a) and does not meet an exemption in §4151.002 or §4151.0021, the person is an administrator for purposes of Chapter 4151 and these rules. Section 7.1601(a), which is adopted without change to the proposed text, clarifies that a person acting as or holding itself out as an administrator may be simultaneously subject to the requirements of other provisions of the Insurance Code, the Labor Code, or rules adopted thereunder if the functions or services performed or offered by that person require such regulation. In such event, the person will be required to hold all appropriate authorizations pursuant to the Insurance Code or the Labor Code in order to perform or offer to perform the regulated functions and services. This is because a single authorization issued pursuant to the Insurance Code or the Labor Code does not authorize a person to perform or offer to perform any additional regulated functions or services than those specified by the authorization. Each authorization relates to specific functions or services regulated under specific Insurance Code or Labor Code provisions. Therefore, a person must hold the applicable authorization in order to perform or offer to perform the corresponding regulated functions or services. The following example is provided for illustrative purposes. A

person holds a certificate issued by the Department pursuant to the Insurance Code Chapter 1305 to operate a workers' compensation network in this state. The person acts as or holds itself out as an administrator by settling a claim on behalf of the insurer that established or contracted with this certified workers' compensation network to provide health care services. Under §4151.001(1), the term "administrator" includes a workers' compensation health care network authorized under Chapter 1305 that administers a workers' compensation claim for an insurer, including an insurer that establishes or contracts with the network to provide health care services. Therefore, in this example, the person will be simultaneously subject to the requirements of the Insurance Code Chapters 1305 and 4151 and the implementing rules of both chapters. The person will be required to hold a separate authorization under each of these chapters in order to perform or provide the functions and services of a workers' compensation network and an administrator.

With regard to the comment requesting that the Department remove all unnecessary duplication of existing statutory or regulatory requirements under the Insurance Code or the Labor Code for administrators, the Department does not have the authority to remove duplicative statutory requirements; only the Legislature can do that. The Department does not agree that there are any duplicative regulatory requirements in these rules. This is based on the Department's preceding review of the individual provisions of these rules and the statutes implemented by these rules. The Department disagrees that §7.1601(a) and page 4 of 158 in the proposal preamble, as the commenter contends, state or imply that duplicative registration or licensing requirements may apply. Instead, §7.1601(a) and page 4 of 158 of the proposal clarify that a person acting as or holding itself out as an administrator may be simultaneously subject to the requirements of other provisions of the Insurance Code, the Labor Code, or rules adopted thereunder if the functions or services performed or offered by that person require such regulation. As previously explained in this response, in such event, the person will be required to hold all appropriate authorizations pursuant to the Insurance Code or the Labor Code in order to perform or offer to perform the regulated functions and services authorized under each of the certificates of authority. This is because the authorization issued to the person under Chapter 1305 to operate as a workers' compensation network in this state only authorizes the specific functions regulated under Chapter 1305. That specific authorization does not authorize the person to perform other activities that are regulated under other Insurance Code or Labor Code provisions. In order for the person to act as an administrator under the Insurance Code Chapter 4151, the person must hold a separate authorization issued pursuant to Chapter 4151. The person will be subject to the requirements of Chapter 1305 and the Chapter 1305 implementing rules for its functions related to operating a workers' compensation health care network. The person will also be simultaneously subject to the requirements of the Insurance Code Chapter 4151 and the Chapter 4151 implementing rules for acting as or holding itself out as an administrator. In order for the person to engage in each of these regulated activities, the person must hold separate authorizations issued under the applicable Insurance Code or Labor Code statutes and must comply with the rules adopted under each of those statutes. Section 7.1601(c) further reinforces this requirement by providing that an administrator must meet the requirements of the Insurance Code Chapter 4151 and these rules in addition to any other requirements that apply to that person as: (i) a delegated entity or a delegated third party administrator of a health maintenance organization (HMO) under the Insurance Code Chapter 1272, (ii) a workers' compensation healthcare network under the Insurance Code Chapter 1305, (iii) a qualified claims servicing contractor under the Labor Code Chapter 407, or (iv) an administrator or service company under the Labor Code Chapter 407A. Further, adopted new §7.1601 and §7.1603 are consistent with the Insurance Code §1305.008. Section 1305.008 requires a person to hold a certificate of authority issued under Chapter 4151 if that person provides the functions of an administrator under Chapter 4151. Currently, Department records indicate that persons holding certificates of authority issued under the Insurance Code Chapter 1305 to operate as workers' compensation networks also hold certificates of authority issued under Chapter 4151 to act as administrators. However, if a person, including a certified workers' compensation network, does not act or hold itself out as an administrator, it would not need to obtain a certificate of authority under the Insurance Code §4151.051 or otherwise need to meet the requirements of the Insurance Code Chapter 4151 and these rules. Moreover, if a person, including a certified workers' compensation health care network, acts or holds itself out as an administrator, but meets an exemption specified in Chapter 4151, then it would not need to obtain a certificate of authority under the Insurance Code §4151.051 or otherwise need to meet the requirements of the Insurance Code Chapter 4151 and these rules pertaining to administrators. Therefore, these rules, as proposed and adopted, do not result in the dual regulation of any persons or entities unless such persons or entities are performing separate functions which require separate authorizations under the applicable statutes. Accordingly, the issuance of a separate statutory authorization, i.e., a certificate of authority to perform the functions of an administrator as specified in Chapter 4151 of the Insurance Code, in addition to other statutory authorizations for the performance of other types of functions not regulated under Chapter 4151 is consistent with the purpose and intent of HB 472.

Vagueness, Confusion, and Substantive Due Process Concerns

Comment: One commenter contends that the proposed language in the rules is so vague and confusing that an insurer or other regulated person does not know if a proposed rule applies to them or what is expected of them. The commenter recommends that the rules be clarified to allow men and women of common intelligence to know if a proposed rule applies to them or what is expected of them. The commenter states that the Texas Constitution, Article I, Sections 13 and 19 guarantees due process; the commenter cites to various court opinions for support. The commenter states that individuals must be afforded both substantive and procedural due process. *(Texas Workers' Comp. Comm'n v. Patient Advocates,* 136 S.W.3d 643, 658 (Tex. 2004)). Substantive due process protects against the arbitrary and oppressive exercise of government power, regardless of the fairness of the procedures. *Daniels v. Williams,* 474 U.S. 327, 331, 88 L. Ed. 2d 662, 106 S. Ct. 662 (1986). A statute which forbids or requires the doing of an act in terms so vague that men and women of common intelligence must necessarily guess at its meaning and differ as to it application violates the first essential protection of due process of law. Baker v. State, 50 S.W.3d 143, 145 (Tex. App.--Eastland 2001, pet. ref'd) *citing Connally v. General Const. Co.,* 269 U.S. 385, 46 S. Ct. 126, 70 L. Ed. 322 (1926). A statute is void for vagueness if it "fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute." *Baker v. State,* 50 S.W.3d at 145; *citing Papachristou v. City of Jacksonville,* 405 U.S. 156, 92 S. Ct. 839, 31 L. Ed. 2d 110 (1972).

Agency Response: The Department disagrees with the commenter. The commenter does not specify which of the rules are vague and confusing. Following a thorough review of the proposed rules, the Department has identified and revised two of the proposed rules to (i) clarify in §7.1613(d)(1) one of the requirements that must be included in each written agreement between an insurer and an administrator; and (ii) clarify in §7.1616(b) the facts and circumstances which may indicate that an applicant or administrator is operating or conducting business in a potentially hazardous or injurious manner to an insured person or the public. These clarifications do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice. Section 7.1613(d)(1) as adopted provides that a written agreement entered into under §7.1613 must include a requirement that the administrator comply with all statutory, contractual, and regulatory requirements related to a function assumed or carried out by the administrator and related to a plan for which the administrator performs or offers to perform administrative services. Section 7.1616(b) as adopted provides that other facts and circumstances not specified in §7.1616(a), as determined by the Commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state may also indicate that an applicant or administrator is operating in a hazardous or injurious manner. The Department is of the opinion that the rules as adopted are not vague and confusing and that a person or entity will be able to determine whether the rules apply to them by a plain reading of the rules. For example, §7.1601(a) states that these rules apply to a person acting as or holding itself out as an administrator in any capacity, regardless of whether the person holds another authorization under the Insurance Code or Labor Code--unless there is an exception or exemption either in these rules or Chapter 4151 of the Insurance Code that results in the rules not being applicable. Section 7.1602(1) defines "administrator" to be an individual or entity that meets the definition of "administrator" in the Insurance Code §4151.001(1). The §7.1602(1) definition further states that the term includes administrator contractors and administrator subcontractors but does not include a person described by the Insurance Code §4151.002 or §4151.0021. Therefore, a person who is trying to determine whether they are required to comply with the rules must read, in addition to the definition of "administrator" in §7.1602(1), the statutory definition of "administrator" in the Insurance Code §4151.001(1) and the definitions of the terms "administrator contractor" and "administrator subcontractor" in §7.1602(3) and (4). The person must also read §4151.002 or §4151.0021 of the Insurance Code to determine if they meet one of the exemptions. In addition, the person must read the entirety of the rules to determine any exemptions or exceptions to the rule requirements. For example, under §7.1603(a), relating to certificate of authority requirements, a person acting as or holding itself out as an administrator is not required to hold a certificate of authority under the Insurance Code Chapter 4151 if the person meets the exemption under the §4151.004. Also, under §7.1605(a), relating to notification requirements, an insurer or HMO that is acting as or holding itself out as an administrator and that is not exempt under the Insurance Code §4151.002(3) or (4) is subject to all provisions of the rules, except §§7.1603, 7.1604, and 7.1609(c) and (d)(1) and (2) (relating to required certificate of authority, certificate of authority application, and annual report). Under §7.1609(d), relating to annual report requirements, an administrator who receives less than $10 million in compensation for providing administrative services in Texas during the preceding calendar year is exempt from the audit report requirements in §7.1609(c). Also, under §7.1611(g), relating to operational review and on-site audit requirements, an insurer may meet the §7.1611 requirements for an administrator subcontractor by reviewing and auditing the administrator contractor only, provided that: (i) the information supplied to the insurer by the administrator contractor includes all necessary and relevant information relating to the administrator subcontractor; and (2) no evidence of material non-compliance by the administrator subcontractor exists. Additionally, §7.1613(b), relating to written agreements between administrators and insurers, provides that an administrator subcontractor may meet the contracting requirements of §7.1613 by entering into a written agreement with an administrator contractor, provided that the written agreement meets the requirements of the Insurance Code Chapter 4151 and §7.1613. The structure of these rules, which references statutory provisions in order to complement many of the rule provisions, is standard rule structure for the Department. Therefore, in order to fully understand and comply with many of the rules, it is necessary to read the rules in conjunction with the statute. This is commonly found in Department rules as well as in other state agency rules. The Department does not agree that this structure results in a rule that is so vague and confusing that it cannot be understood by persons of ordinary intelligence. These rules are necessary to implement the provisions of Chapter 4151. Therefore, the rules either reference applicable provisions of Chapter 4151 (and therefore must be read in conjunction with these sections) or simply specify the requirements necessary to implement the provisions of Chapter 4151. The following are several examples: (i) §4151.002 and §4151.0021, relating to exemptions, are addressed in §7.1601(e) and §7.1602(1), (3) and (4); (ii) §§4151.006, 4151.101, 4151.102, 4151.103(a), 4151.1042(a), 4151.110, and 4151.257, relating to written agreements, are addressed in §7.1613; (iii) §4151.051, relating to certificate of authority requirements, is addressed in §7.1603; (iv) §4151.052(b), relating to Department notification requirements, is addressed in §7.1606 and §7.1607; (v) §4151.1042, relating to review and on-site audit requirements, is addressed in §7.1611; (vi) §§4151.106 - 4151.108, relating to fiduciary duty and account requirements, are addressed in §7.1612; (vii) §4151.205, relating to annual reporting requirements, is addressed in §7.1609; and (viii) §4151.301(8), relating to hazardous or injurious operating conditions, is addressed in §7.1609(e) and §7.1616.

The Department understands that HB 472, which brings all workers' compensation administrators into the regulatory framework of Chapter 4151 and under the regulatory purview of the Department, enacts a significant change that may be difficult for those persons who have not been previously regulated by the Department. As a result, the Department has endeavored to develop rules that are as simplified, and therefore as understandable, as possible, for those persons who are new to such regulation.

Regulation of Law Firms and/or Individual Attorneys as Administrators

Comment: One commenter objects to the regulation of individual attorneys and/or law firms as administrators under the proposed rules. A second commenter requests clarification in the rules as to whether and to what extent an individual attorney or a law firm can be regulated as an "administrator" under the proposed rules or the Insurance Code Chapter 4151. The first commenter raises several constitutional and separation of powers issues and a legislative intent argument to support the position that an attorney or law firm cannot be regulated as a third-party

administrator under Chapter 4151 of the Insurance Code. The commenter's constitutional objections include: (i) any attempt to include law firms in the group of organizations requiring licensure under Chapter 4151 carries separation of powers concerns and would be unconstitutional under the Texas Constitution, Section I, Article II; (ii) there is a 1999 Texas Supreme Court case to support the principle that regulation of attorneys and the firms in which they organize is the responsibility of the Supreme Court of Texas and the State Bar of Texas; (iii) because the regulation of the practice of law by attorneys and the law firms they work for is the responsibility of the Supreme Court of Texas and the State Bar of Texas, any attempt by the Department to impose a licensure obligation on law firms would impinge upon the authority of the Texas Supreme Court and the State Bar of Texas to regulate the practice of law; and (iv) because the authority to license attorneys (and the law firms by which many of them are organized) rests with the Supreme Court of Texas, and because such authority is grounded in the Texas Constitution, it is doubtful whether an express legislative grant of licensure authority to an administrative agency with regard to licensure of law firms would be constitutional. The commenter's objections also include: (i) a common thread running throughout the Insurance Code Chapter 4151 is the Legislature's attempt to enlarge the Department's regulatory authority without impinging upon other regulatory schemes; the structure of the Insurance Code and the background and purpose of HB 472, as described in the bill analysis, make it apparent that the intent of the Legislature in HB 472 is to include workers' compensation administrators within the regulatory purview of the Department so long as the administrators were otherwise administratively unregulated; (ii) the statute provides an exemption for licensed adjusters, but offers no similar exemption for adjusting companies and at first glance, there appears to be parallel regulatory intent with regard to attorneys, but on closer examination, it should be evident that the Legislature never intended to include individual attorneys or law firms in that group of organizations requiring licensure under Chapter 4151; (iii) semi-annual audits and on-site examinations by the Commissioner would be administratively difficult, if not impossible, to implement and might run afoul of the attorney-client privilege; (iv) a law firm is not a third-party administrator; (v) attorneys do not adjust claims; they provide legal representation to self-insurance groups, insurers, and third-party administrators; and (vi) the Legislature has not expressly delegated licensure authority to the Department, and therefore, the Department does not have legislative or other authority to designate and regulate attorneys and law firms as third-party administrators. According to the second commenter, the statute contains an express exemption for licensed attorneys, but not for law firms comprised of licensed attorneys. This commenter asserts that clearly an individual attorney that adjusts or settles workers' compensation claims is not considered an "administrator" under the Insurance Code §4151.002(12). This commenter states that arguably under the statute, law firms who "adjust or settle" workers' compensation claims are required to obtain a certificate of authority as an "administrator," just as independent adjusting firms must do. This commenter states that the Insurance Code Chapter 4151 and the proposed rules do nothing to clarify the question of whether law firms should be considered as administrators.

Agency Response: The Department agrees that regulating the practice of law by individual attorneys and law firms is the responsibility of the Supreme Court of Texas and the State Bar of Texas. The Department also agrees that the Department does not have legislative or other authority to regulate individual attorneys and law firms to the extent that they are engaging in the practice of law. Therefore, the Department has not historically attempted to apply Chapter 4151 or the existing administrator rules to individual attorneys or law firms practicing law; no change in this practice is intended by these rules, either as proposed or adopted. Section 4151.001(1) defines "administrator" in pertinent part to mean "a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. . . . The term does not include a person described by Section 4151.002." Section 4151.002(12) provides that a person is not an administrator if the person is "a person who adjusts or settles claims in the normal course of the person's practice or employment as a licensed attorney and who does not collect any premium or charge in connection with annuities or with life, health, accident, pharmacy, or workers' compensation benefits. (emphasis added) Therefore, under §4151.001(1) and §4151.002(12), if an individual attorney adjusts or settles claims in the course of his/her practice and collects any premium or charge in connection with annuities or with life, health, accident, pharmacy, or workers' compensation benefits, the individual attorney is not eligible for the exemption under the Insurance Code §4151.002(12).

Law firms are clearly not required to obtain a certificate of authority as an "administrator" under the Insurance Code Chapter 4151 to engage in the practice of law. As previously stated, §4151.001(1) defines "administrator" in pertinent part to mean "a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. . . . The term does not include a person described by Section 4151.002." Section 4151.051(a) provides that "an individual, corporation, organization, trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under" Chapter 4151 of the Insurance Code. Therefore, under the provisions of §4151.001(1) and §4151.051(a), any law firm whose activities go beyond the practice of law by virtue of acting as or holding itself out as an administrator as defined in the Insurance Code §4151.001(1), must hold an administrator certificate of authority and comply with the requirements in these rules and Chapter 4151, unless otherwise exempt under the Insurance Code or Labor Code.

Exemption for Pharmacy Benefit Managers

Comment: One commenter states an exemption for a pharmacy benefit manager (PBM) may exist under the Insurance Code §4151.002(14) because most, if not all, PBMs perform some kind of clinical review (either in house or contract) and some have clinical pharmacists on board to coordinate this type of service. According to the commenter, (i) PBMs provide technical, advisory, and consulting services as well, but do not make any decisions on behalf of the insurer or third party administrator; (ii) a PBM could be defined as a processing agent under the Insurance Code §4151.0021 and the Labor Code §413.0111; and (iii) PBMs do not collect premiums or contributions, nor do they adjust or settle any claims in the state of Texas (or any state).

Agency Response: While the Department agrees that certain PBMs may meet the exemption under the Insurance Code §4151.002(14) or the exemption under the Insurance Code §4151.0021 for certain workers' compensation processing agents, the Department does not agree that all PBMs will

meet one of these exemptions. PBMs may perform a variety of functions that at times may include (i) contracting with a network of pharmacies; (ii) establishing payment levels for provider pharmacies; (iii) negotiating rebate arrangements; (iv) developing and managing formularies, preferred drug lists, and prior authorization programs; (v) maintaining patient compliance programs; (vi) performing drug utilization review; and (vii) operating disease management programs and mail order services. The Insurance Code §4151.151 specifically provides that the term "pharmacy benefit manager" means a person, other than a pharmacy or pharmacist, who acts as an administrator in connection with pharmacy benefits. Therefore, a person that meets the definition of a "pharmacy benefit manager" in the Insurance Code §4151.151 is considered an "administrator" for purposes of Chapter 4151 and these rules and is subject to regulation under Chapter 4151 and these rules. This includes the requirement to obtain a certificate of authority to act as administrator under the Insurance Code Chapter 4151. Currently, approximately 30 entities describing themselves as PBMs or as providing PBM functions hold administrator's certificates of authority issued by the Department under Chapter 4151.

Whether any person, including a PBM is an "administrator," as defined in the Insurance Code §4151.001(1) and §7.1602(1), or meets an exemption described in §4151.002 or §4151.0021 is based entirely on the particular facts and circumstances and the various functions or services being performed or offered to be performed by the PBM. The Department determines whether a PBM is an "administrator" as defined in the Insurance Code §4151.001(1) and §7.1602(1) or meets an exemption under §4151.002 or §4151.0021 in the same manner that it makes this determination for any other person. The determination is based upon a case-by-case analysis of the particular facts and circumstances, including the contractual and employment relationship and the actual services and functions being performed or offered to be performed. To the extent any person, including a PBM, collects premiums or contributions, or adjusts or settles claims, or offers to provide these administrative services, for residents of this state in connection with annuities or life, health, accident, pharmacy, or workers' compensation benefits and does not meet an exemption under the Insurance Code §4151.002 or §4151.0021, the person is an administrator under Chapter 4151 and these rules. As such, the person is subject to the requirements in Chapter 4151 and these rules, including the requirement to obtain a certificate of authority from the Department to act as an administrator under the Insurance Code Chapter 4151. This is true regardless of whether the person, including a PBM, is also performing or offering to perform functions or services in addition to collecting premiums or contributions or adjusting or settling claims.

Requested Definitions for the Terms "adjust" and "settle"

Comment: Three commenters recommend that the proposed rules define the terms "adjust," "adjusts," "adjusting," and/or "settle." One of these commenters specifically recommends including in the rules a definition of the terms "adjusts" and "adjusting" to state "the investigation, management, supervision of the handling of or settling of losses on behalf of an insurer, administrator, plan, plan administrator or plan sponsor." This commenter states that the rules need to clarify the terms "adjusting" and "adjust" in order to restrict the scope of the rules to individuals and entities that actually collect premiums or adjust or settle claims and to exclude "down stream" contractors (vendors) of insurers and sub-contractors (vendors) of third-party administrators that do not have the ultimate decision-making authority when handling aspects of insurance claims, e.g., legal representation, utilization review, peer review, case management of workers' compensation medical benefits, etc. The other two commenters note that neither the Insurance Code 4151 nor the proposed rules define the terms "adjust" or "settle" or "adjusts" or "settles." One of these commenters states that the terms "adjust" or "settle" are key to understanding the intended scope of the rule. The other commenter states that adjusters are frequently asked to performed limited assignments on behalf of insurers. The commenter contends that if their activities can be considered to be "adjusting" or settling," then the commenter assumes that these persons must be licensed as "administrators," but that the rules are not clear on that point.

Agency Response: The Department does not agree that it is necessary to define these terms and believes that to do so could result in unnecessary ambiguity. The rules in §§7.1601 - 7.1605, 7.1607, 7.1609, 7.1611, and 7.1613 - 7.1617 clearly and appropriately incorporate the terms "adjusting" and "settling" as used in the Insurance Code Chapter 4151, including in the definition of the term "administrator" in §4151.001(1). The Insurance Code Chapters 4101 and 4102 regulate adjusters and adjusting and prescribe the requirements applicable to obtaining an adjuster's license. The Department declines to adopt a more narrow definition of "adjusting," "adjust," "adjusts," or "settle" than may be contemplated by these chapters. Any definition of these terms in these adopted rules may have an unanticipated effect upon the application of the term "adjust," "adjusts," "settles," or "adjuster" in these chapters or in the interpretation of the term "claims adjuster" in other Code provisions or Department rules. The Department has had experience applying the statutory terms in the Insurance Code Chapter 4151 prior to the enactment of HB 472 in the context of life, health and annuities business, and has encountered no problems applying them. Department experience demonstrates that whether or not an activity falls within the meaning of the statutory terms "adjusts" or "settles" claims necessitates a fact-specific, case-by-case determination. Therefore, the Department disagrees that the rules must define these terms in order to determine the proper scope of the applicability of the rules.

Requested Definitions for the Terms "discretionary decision" and "management decision"

Comment: One commenter requests that the terms "management decision" and "discretionary decision" be defined in the rules to provide that the decisions must be final, ultimate decisions on an aspect of how the claim is to be handled and adjusted. The commenter further recommends that the definitions provide that administrator contractors and vendors who do not make final, ultimate decisions or are limited by contract or a master services agreement shall be deemed as not possessing the authority to make management and discretionary decisions for the purpose of the application of the rules. Another commenter states that it is a "fine point" whether certain activities described in its comment involve "management or discretionary decisions" on behalf of the insurer and that the rules do not provide effective guidance. The commenter questions how may one act as a utilization review agent, or handle precertification requests, or audit medical bills, or assist carriers by setting up independent medical examinations or peer reviews without making any discretionary decisions as implied by the Insurance Code §4151.002(14). The commenter further states that it is unclear if certain activities of private investigation companies involve "discretionary decisions" and therefore, would not be exempted under the Insurance Code §4151.002(14). This includes

private investigation companies who are hired to perform investigations in workers' compensation claims, such as taking statements, and who sometimes are given authority to make discretionary decisions for carriers and third-party administrators. Additionally, the commenter contends that arguably the following activities involve "discretionary decisions" and thus would not be exempted under the Insurance Code §4151.002(14): (i) attendance by a carrier's "representative" (a term which includes attorneys and adjusters) at a benefit review conference on behalf of a carrier; (ii) independent adjusters who perform investigations, which may involve discretionary decision-making; and (iii) adjusters who propose language to resolve disputed issues concerning workers' compensation benefits or who decide whether to file a dispute on behalf of a carrier.

Agency Response: The Department does not believe that it is necessary to define the terms "discretionary decision" or "management decision" and that to do so could result in unnecessary ambiguity or have an unanticipated effect upon the application of the term "administrator" in Chapter 4151 or the adopted rules. The Insurance Code Chapter 4151 uses the terms "management or discretionary decisions" in the exemption to the term "administrator" enumerated in §4151.002(14). Any person determined to make any management or discretionary decisions on behalf of an insurer, HMO, group, plan, or plan sponsor regarding the settlement or adjustment of claims for or collection of premiums or contributions from residents of this state in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits does not meet the exemption in §4151.002(14), and is an administrator for purposes of regulation under Chapter 4151 and these rules--unless the person meets another exemption in §4151.002 or the exemption in §4151.0021. Under the Insurance Code §4151.001(1) and §4151.051(a) and §§7.1601, 7.1602(1), and 7.1603, for a person to be considered an administrator under Chapter 4151 and the rules, the person first has to perform or offer to perform the adjustment or settlement of claims for or collection of premiums or contributions from residents in this state in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits. If a person is performing or offering to perform one of more of these administration functions, the Department then determines if the person meets a statutory exemption, including but not limited to the exemption provided in the Insurance Code §4151.002(14). Section 4151.002(14) provides that a person is not an administrator if the person "provides technical, advisory, utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor but does not make any management or discretionary decisions on behalf of an insurer, plan, or plan sponsor." Whether any person, including those persons mentioned by one of the commenters, is delegated management or discretionary authority or makes management or discretionary decisions regarding the settlement or adjustment of claims for or collection of premiums or contributions on behalf of an insurer, plan, or plan sponsor is determined on a case-by-case, fact-specific basis. For example, one element of consideration in the Department's determination of whether a person is an administrator is the identity of the party that is responsible for the day-to-day management of the premium collection, claim payment, and/or adjustment functions and which party has final decision-making authority for the payment of claims. Also, a second element is whether there are any limitations in written agreements that prohibit a person from making a discretionary decision or management decision. Another important element is the actual services or functions being performed or offered to be performed by the person, rather than the title or name used to describe the person. The Department has applied the exemption in the Insurance Code §4151.002(14) on a case-by-case, fact-specific basis to regulatory situations related to annuities, or life, health, accident benefits since at least September 1, 1989, when Chapter 4151 (formerly Article 21.07-6) was first enacted. It is the Department's experience that this application has not resulted in undue burdens on the insurance industry or individuals or entities or in implementation or compliance difficulties. Under these rules, the Department will continue the practice of determining the applicability of exemptions listed in §4151.002 and §4151.0021 on a case-by-case, fact-specific basis, applying the ordinary meaning of the words used in the exemptions.

The Department disagrees with the commenter recommending that the rules provide that administrator contractors and vendors who do not make final, ultimate decisions or are limited by contract or a master services agreement shall be deemed as not possessing the authority to make management and discretionary decisions for the purpose of the application of the rules. Section §4151.002(14) does not contain such limitations, and the Department does not have the authority to limit §4151.002(14) in accordance with the commenter's suggestion.

With regard to workers' compensation benefits, the Department is aware that many parties are involved in processing these types of benefits and anticipates that the Department's fact-specific determination will reflect that a relatively large number of these persons meet the statutory exemption in §4151.002(14). Nevertheless, the Department also believes that it is possible that certain persons who act as utilization review agents, handle precertification requests, audit medical bills, perform investigations, or assists carriers by setting up independent medical examinations or peer reviews may also perform the functions of an administrator under Chapter 4151 by making management or discretionary decisions on behalf of the insurer, plan, or plan sponsor, while engaged in the process of adjusting or settling claims, collecting premiums or contributions, or offering to perform these functions or services.

The Department agrees that independent adjusters who perform investigations and who make discretionary decisions and adjusters who propose language to resolve disputed issues concerning workers' compensation benefits or who decide whether to file a dispute on behalf of a carrier are not exempt under §4151.002(14). However, §4151.002(13) contains an exemption from Chapter 4151 regulation for individual adjusters "engaged in the performance of an individual's powers and duties as an adjuster in the scope of the individual's license." Moreover, §4101.001 of the Insurance Code defines an adjuster as an individual whose functions include, but are not limited to, investigating, adjusting and supervising the handling of workers' compensation claims, including performing these functions on behalf of an administrator. Thus, although the Department's fact-specific determination may yield a different result, the Department anticipates that many individual adjusters will be exempt from Chapter 4151 regulation under §4151.002(13). Those individual adjusters that function within the scope of their license as an adjuster are not subject to the certificate of authority and other requirements of Chapter 4151.

Interpretation of the Insurance Code §4151.0051, relating to Referral to Adjuster by Administrator

Comment: One commenter inquires whether, under the Insurance Code §4151.0051, an administrator may refer a claim or loss for adjustment in this state to not only an individual purport-

ing to be acting as an adjuster as long as that individual holds an adjuster license under the Insurance Code Chapter 4101, but also to independent adjusting firms that do not hold certificates of authority as administrators under the Insurance Code Chapter 4151. The commenter states that neither the statute nor the proposed rules make this clear.

Agency Response: §4151.0051 does not authorize or permit an administrator to refer a claim or loss for adjustment to an independent adjusting firm that does not hold a certificate of authority under the Insurance Code Chapter 4151. Instead, §4151.0051(a) prohibits an administrator from knowingly referring a claim or loss for adjustment in this state to an individual purporting to be or acting as an adjuster unless the individual holds a license under Chapter 4101. Additionally, the Insurance Code §4151.1041(a) prohibits a carrier from knowingly referring a claim or loss for administration in this state to a person purporting to be or acting as an administrator, unless that person holds a certificate of authority under Chapter 4151. Section 4151.1041(b) requires a carrier to ascertain from the Commissioner whether the person performing the administration holds a certificate of authority under Chapter 4151 before referring a claim or loss for administration.

Confidentiality Concerns

Comment: One commenter objects to the definition of "Records" in proposed §7.1602(20) because it includes pleadings and investigatory files. The commenter contends that the definition should be revised to provide that a third-party administrator does not have to release records that are confidential, privileged, or proprietary in nature and requests that the definition in §7.1602(20) be revised to omit pleadings and investigatory files and to add "excluding records that are privileged, confidential, and proprietary in nature." To support the requested changes, the commenter states that in most cases, third-party administrators do not possess legal pleadings related to administrative law and legal proceedings and investigatory files associated with a claim as these documents are most often maintained by the law firm that represents the insurer or plan or private investigation firm that provides special investigation unit services to the insurer or plan. Another commenter recommends that the proposed rules contain a confidentiality provision that requires the Department to maintain any information it obtains or audits in a confidential manner and that such information remain free from all disclosure to third party requirements. The commenter states that the proposed rules require that administrators and insurers provide many documents, records, and other information to the Department. The commenter states that many of the records or other information required to be provided will contain confidential and proprietary information, and that release of such information to third parties would raise serious competitive issues.

Agency Response: The Department declines to make the recommended changes. Section 7.1602(20) simply defines "Records" as written or electronic material directly or indirectly relating to the business of an administrator and provides some illustrative examples of material that may constitute records for purposes of the rules and the Insurance Code Chapter 4151. Section 7.1602(20) does not require an administrator to possess or maintain possession of pleadings or investigative files. If the administrator does not possess or maintain such files, that is of no consequence under these rules. A review of the rules that address an administrator's records indicates that it is not within the ambit of these rules to determine what records are privileged, confidential, or proprietary in nature. The rules do not affect any of the laws that make any of the records privileged, confidential, or proprietary in nature. These rules include (i) §7.1612(f), which requires an administrator to properly maintain detailed accounting records that document all deposits and withdrawals from a fiduciary account; (ii) §7.1612(h), which provides that all records maintained by an administrator relating to any premium shall be subject to examination by the Commissioner upon request; (iii) §7.1613(e), which requires a written agreement entered into under §7.1613 to ensure that the books and records of the insurer remain the property of the insurer at all times, and are available to the insurer or its designee at any time while in the custody of the administrator; (iv) §7.1615, which establishes requirements related to the timely transfer of the books and records of an insurer upon the termination of the relationship with the insurer; and (v) §7.1616(a)(4), which provides that failure to maintain records sufficient to permit examiners to determine an applicant's or administrator's financial condition or compliance with the Insurance Code, Labor Code, or rules adopted thereunder may be considered by the Department in determining whether an applicant or administrator is operating or conducting business in a potentially hazardous or injurious manner. The definition and use of the term "record" or "records" in the rules is consistent with the Insurance Code Chapter 4151, including §4151.006 relating to the Department's rulemaking authority; §4151.101 relating to the required written agreement with the insurer or plan sponsor; §4151.102 relating to the required contents of the written agreement; §4151.103(a) relating to the retention of the written agreement; §4151.103(d) relating to prescribing rules for the transfer of records from one administrator to another administrator; §4151.1042(a) relating to prescribing the administrator responsibilities in the written agreement; §4151.110 relating to prescribing the underwriting standards of the insurer or plan in the written agreement; §4151.257 relating to adopting rules to implement the requirements of Subchapter F, including rules prescribing requirements for contracts and master services agreements and requirements for the payment of claims; and §4151.301(11) relating to grounds for denial, revocation, or suspension of a certificate of authority. Additionally, the Department does not have the statutory authority to maintain in a confidential manner all information that it obtains or audits or to maintain such information in a way that is free from all disclosure to third parties, as requested by one of the commenters. The Legislature has addressed the confidentiality of certain documents in the Insurance Code Chapter 4151, including §§4151.103(c), 4151.113(b), 4151.115(a), and 4151.205(e). Section 4151.103(c) provides that information the Commissioner or the Commissioner's designee obtains from the written agreement is confidential and may not be made available to the public. Section 4151.113(b) provides that a trade secret, including the identity and address of a policyholder, certificate holder, or injured employee, is confidential, except the Commissioner may use that information in a proceeding against the administrator. Section 4151.115(a) provides that information that identifies an individual covered by a plan is confidential. Section 4151.205(e) provides that information derived from an audited financial statement contained in an annual report under §4151.205 is confidential and is not subject to disclosure under Chapter 552, Government Code. The Department is subject to these confidentiality provisions, as well as other confidentiality provisions in Texas and federal statutes, and follows the provisions of the Government Code Chapter 551 regarding whether information is deemed public and subject to disclosure.

Comment: One commenter recommends that proposed §7.1609 be revised to provide that financial information submitted with an annual report is confidential as provided by the Insurance Code §4151.205(e).

Agency Response: The Department declines to make the suggested change. The Department disagrees that the Insurance Code §4151.205(e) deems all financial information submitted with an annual report to be confidential and not subject to disclosure under Chapter 552, Government Code. The Insurance Code §4151.205(e) provides that "Information derived from an audited financial statement contained in an annual report" under the Insurance Code §4151.205 "is confidential and is not subject to disclosure under the Government Code Chapter 552." The Department is subject to the confidentiality provision in the Insurance Code §4151.205(e), and thus, will treat information derived from an audited financial statement contained in an annual report as confidential and not subject to disclosure under Chapter 552, Government Code. If the Department receives an open records request for information derived from an audited financial statement contained in an annual report or the audited financial statement itself, the Department will obtain a determination from the Office of the Attorney General regarding whether to release or not release the requested information. Also, under the Insurance Code §4151.113(b), trade secrets, claimed by third party administrators, including the identity and addresses of policyholders and certificate holders, are confidential, except the Commissioner may use that information in a proceeding against a third party administrator. If the Department receives an open records request for information that an administrator has claimed a proprietary or privacy interest in (e.g., trade secret), the Department will obtain a determination from the Attorney General's office regarding whether to release or not release the information to the requestor. The Department also will send a letter, in a form required by the Attorney General, to the administrator notifying the administrator of the request and explaining the process for making arguments to the Attorney General.

Public Benefit/Cost Note: Anticipated Public Benefits

Comment: One commenter disagrees with the Department's discussion of the "anticipated public benefits" on pages 59 - 60 of 158 of the proposal published in the *Texas Register* on December 5, 2008 (33 TexReg 9904) which, according to the commenter, characterizes the multiple licensure requirements for applicants as "more efficient and standardized" (page 59) or "more efficient and consistent regulation of the industry" (page 60). This commenter contends that a more efficient and standardized process would be using existing certifications in lieu of requiring new and duplicative registration and licensure requirements.

Agency Response: The Department disagrees with the commenter's characterization that the Department stated or implied in the proposal that the multiple licensure requirements for applicants are "more efficient and standardized" (page 59) or "more efficient and consistent regulation of the industry" (page 60). The statement on page 59 specifies that "The anticipated public benefits include: (i) a more efficient and standardized process for regulating administrators, resulting in ease of operations and processes for the industry and the Department;. . . ." Page 60 of the proposal states in relevant part that: "The proposal also clarifies the requirements of Chapter 4151 for persons holding other authorizations issued under the Insurance Code or the Labor Code. This clarification is particularly significant because a person may be simultaneously subject to the requirements of different provisions of the Insurance Code, the Labor Code, or rules adopted thereunder based upon the diversity of the functions performed by that person. In such situations, a person may be required to hold one or more authorizations issued under the Insurance Code or the Labor Code in order to perform those regulated functions. By providing additional guidance to applicants and administrators regarding their obligations under Chapter 4151, it is anticipated that a greater number of applicants and administrators will comply with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder. This should result in more efficient and consistent regulation of the industry." (emphasis added). These statements simply indicate that the proposed rules will result in a more efficient, consistent, and standardized process for regulating administrators and the industry, in part, by clarifying the requirements of Chapter 4151 for persons holding other authorizations issued under the Insurance Code or the Labor Code.

Public Benefit/Cost Note: Adequacy of Cost Note for Operational Review and On-Site Audit Requirements in §7.1611

Comment: A commenter disputes the adequacy of the part of the cost note outlining the anticipated costs of the semi-annual operational reviews and biennial on-site audits of administrators required by proposed §7.1611. The commenter expresses appreciation for the flexibility the proposed rule would allow for the location of the operational reviews and for the provision that would allow a member of the insurer's staff to conduct an on-site audit. However, the commenter expresses concern that the requirements for these reviews and on-site audits will result in unnecessary extra costs. The commenter points out that page 93 of the proposal states that the "department anticipates" that a member of the insurer's management staff could complete a review of an administrator in less than four hours and that a member of the insurer's staff could complete an on-site audit in a minimum of eight hours. According to the commenter, the cost for an insurer's operational review or on-site audit of an administrator would result in higher overall expenses than stated in the cost note. The commenter estimates that each operational review and on-site audit would require a minimum of 40 hours on average and would require travel to the administrator's offices. The commenter's estimated cost for each on-site audit and operational review that requires travel to the administrator's offices is a "conservative" estimate of $5,076.

Agency Response: The Department disagrees that its cost estimates and relevant cost factors for the required semi-annual reviews and biennial on-site audits were underestimated for the following reasons. First, while the commenter correctly points out that page 93 of the proposal states that the Department anticipates that a member of an insurer's management staff could typically complete a review of an administrator in less than four hours and that a member of the insurer's staff could complete an on-site audit in a minimum of eight hours, the Department's cost note also clearly and unambiguously states that the probable costs of compliance with proposed §7.1611 would vary substantially among insurers depending upon several factors. These factors, as listed in the cost note, are: (i) the number of administrators the insurer is required to review and audit; (ii) the size and complexity of the organization of each administrator the insurer is required to review and audit; (iii) the number of hours an insurer needs to review a particular administrator's information; (iv) the adequacy of each administrator's books and records; (v) whether an administrator's internal controls are adequate; (vi) whether the insurer is already reviewing and auditing a particular administrator; (vii) whether the insurer is able to review the administrator through electronic means; and (viii) whether an in-

surer discovers substantial problems during a review or audit, including the depth and complexity of those problems. Moreover, the Department stated in the proposal that its estimated costs may increase substantially depending upon whether a particular insurer discovers problems during a particular review or on-site audit that requires additional review and attention. Second, the Department's cost note also states that the §7.1611 review and on-site auditing requirements are consistent with prudent business practices. Therefore, the Department did not anticipate that most insurers utilizing the services of an administrator would need to make significant changes to their current review and auditing methods, systems, practices, and procedures. Third, the Department's cost note indicates that certain insurers may already have certain review or auditing procedures in place that meet all or the majority of the §7.1611 requirements. Fourth, the Department's cost note points out that §7.1611 does not dictate the precise methods, practices, systems, or procedures that must be utilized by an insurer during its review or on-site audit of an administrator. Therefore, §7.1611 provides each insurer with the flexibility to use the most economical means of compliance with the §7.1611 requirements. Fifth, the Department's cost note explains that §7.1611 provides options for compliance with the various requirements. Therefore, insurers are able to select options that will result in less costs being expended. For example, the insurer can perform the operational review through electronic means. Also, §7.1611(a) permits an insurer to conduct a review of an administrator on its own premises or at another designated location. This allows an insurer to choose the most economical location for performing its review. Section 7.1611(c) permits an insurer to forego one operational review of an administrator in the same fiscal year in which the insurer conducts an on-site audit of the same administrator pursuant to §7.1611(b). This will reduce the number of reviews required and thus decrease the costs of those reviews. Another option for compliance is in §7.1611(f), which permits an on-site audit to be conducted by an insurer or an insurer's designated representative. Because the requirements as proposed did not require an on-site audit to be conducted by an actuary or an independent CPA, the cost note indicated that an insurer could use its own employees to conduct an on-site audit. This will also result in costs savings. Additionally, §7.1611(g) allows an insurer to forego an additional review and on-site audit of an administrator subcontractor under two specific circumstances: (i) the review and on-site audit of the administrator contractor contains adequate information about the administrator subcontractor; and (ii) there is no evidence of material non-compliance by the administrator subcontractor. This option will result in fewer reviews and audits and thus result in costs savings for insurers. Sixth, the Department has considerable experience with conducting reviews and on-site examinations of insurers, including a review of the totality of their operations, financial condition, and business operations. These reviews and examinations of insurers are considerably more substantial, complex and time-consuming than the reviews and operations required by §4151.1042(c) and §7.1611. The Department, however, because of similar cost factors, was able to rely on this experience to develop probable anticipated costs and relevant cost factors for persons to comply with proposed §7.1611. Finally, the Department clearly states in the proposal cost note that each insurer has the information necessary to estimate its own compliance costs. Therefore, the Department believes that the commenter's objection is without basis because the commenter did not take into account all of the relevant cost estimate factors in the cost note for proposed §7.1611.

The commenter's own cost estimate for conducting both operational reviews and on-site audits is overstated because it includes one week's worth of related travel and lodging expenses for operational reviews. Section 7.1611 of the rule does not require on-site travel for operational reviews. As previously explained, §7.1611 includes several options to give insurers flexibility to reduce their costs of compliance, including the ability to conduct reviews at any location and by electronic means, which is intended to eliminate required travel costs and reduce the overall costs of the reviews. Similarly, §7.1611 does not require that the totality of an audit be conducted on-site at an administrator's place of business. Rather, the Department anticipates that a significant amount of preparatory and other work could be performed either before or after the on-site presence at an administrator's place of business. As stated in §7.1611(e), the purpose of the on-site audit required by §7.1611(b) is to verify the accuracy, integrity, and completeness of the information received during a review conducted by the insurer pursuant to §7.1611(a). In addition to the requirements in §7.1611(d), an on-site audit conducted by a insurer under §7.1611(b) must also include a physical inspection of the administrator's place of business and a written assessment of the reliability of the information provided to the insurer and relied upon by the insurer when conducting a review or on-site audit of the administrator under §7.1611. More specifically, §7.1611 requires certain incremental work that is specified in §7.1611(e) be conducted on-site at an administrator's place of business. However, allowing a significant amount of the work to be performed either before or after the on-site component of an audit will also assist in reducing the costs of compliance. Finally, many, if not most, of the costs concerning operational reviews and on-site audits are the result of the legislative enactment of the Insurance Code §4151.1042 operational review and audit requirements, rather than the result of the requirements in these rules.

Definition of the Term "Administrator" in §7.1602(1) and Use of the Terms "Administrator Contractor" and "Administrator Subcontractor"

Comment: One commenter objects to all references to the terms "administrator contractor" and "administrator subcontractor" in the rules, including in proposed §7.1602(1), (3), and (4), proposed §7.1603(b), and proposed §7.1611(g), because the terms are confusing, overly burdensome, and beyond the scope of the enabling statutes in the Insurance Code Chapter 4151. Three other commenters object to the definition of "administrator" in proposed §7.1602(1) because it is overly broad, unclear, or exceeds the Department's rulemaking authority by including the terms "administrator contractors" and "administrator subcontractors." One commenter requests that the Department delete proposed §7.1603(b) and remove all references to "contractors" and "subcontractor" in proposed §7.1611(g) and limit the obligations of the insurer to inspection of "administrator," and either: (i) remove all references to "administrator contractor" and "administrator subcontractor" in the rules and use the definition of "administrator" provided in the Insurance Code §4151.001(1); (ii) remove all references to "administrator contractor" and "administrator subcontractor" in the rules and amend the definition of "administrator" to state "a person . . . who, under contract or subcontract, makes discretionary decisions on behalf of an insurer, plan, or plan sponsor of ultimate claim acceptance and/or settlement. . . ."; or (iii) at a minimum, clarify each definition for "administrator contractor" and "administrator subcontractor" by stating that it "excludes entities that, under contract or subcontract, do not make discretionary decisions on behalf of an insurer,

plan, or plan sponsor of ultimate claim acceptance and/or settlement. The reasons provided by the commenter to support its objections and requested changes are: (i) "administrator contractors" and "administrator subcontractors," as those terms are defined in proposed §7.1602(3) and (4), and the duties performed by contractors and subcontractors, fall within the exception of the Insurance Code §4151.002(14), in that they are clearly providing the specified services to the administrator under contract, and the Department itself recognizes that it is the administrator, on behalf of the insurer, who is ultimately responsible for making the management and discretionary decisions, referencing the Insurance Code §4151.1042(a) and the preamble section of the proposal at page 33 of 158 ("each insurer retains the ultimate responsibility for all of its delegated duties, regardless of whether they are performed by an administrator contractor or an administrator subcontractor"); (ii) to give the exception in the Insurance Code §4151.002(14) its plain meaning, the definitions of "contractor" and "subcontractor" must be eliminated from the final rule, citing the Government Code §311.011(a), which provides that words and phrases shall be read in context and construed according to the rules of grammar and common usage; (iii) the definition of "administrator" in the Insurance Code §4151.001(1) only includes or defines two types of delegated entities to which the provision applies (delegated entities under the Insurance Code Chapter 1272 and certified workers' compensation networks under the Insurance Code Chapter 1305), citing case law *(State v. Mauritz-Wells Co.,* 175 S.W.2d 238, 241 (Tex. 1943): "It is a settled rule that the express mention or enumeration of one . . . thing . . . is equivalent to an express exclusion of all others."); *(Harris County v. Dowlearn,* 489 S.W.2d 140, 146 (Tex. Civ. App.--Houston [14th Dist.] 1972, writ ref'd n.r.e.) (same); and (iv) the Department confirmed that it does not intend to regulate contractors and subcontractors in a November 4, 2008 meeting when it represented that it is not the Department's intent to regulate anyone other than someone performing an adjusting function. The commenters objecting to the definition of "administrator" in proposed §7.1602(1) state that the proposed definition: (i) does not follow the definition of "Administrator" in the Insurance Code §4151.001(1) because it adds the sentence "The term includes administrator contractors and administrator subcontractors"; the Department does not have the authority to modify or amend the statutory definition of the term through rulemaking, and the commenter cites case law to support this assertion *(Cruse v. Texas Department of Transportation,* 2007 WL 1345433 (Tex. App.--Amarillo May 8, 2007, no pet.) and *Hollywood Calling v. Public Utility Commission,* 805 SW 2d 618 (Tex. App.--1991)); (ii) is unclear and needs to be limited to a person that has the authority to manage a claim payment account or fiduciary bank account or that has management authority to oversee the adjusting and settling of claims on behalf of an insurer; and (iii) is overly broad and could lead to confusion about what entities are considered, by law, to be administrators or result in possible inadvertent violations by carriers and/or vendors. One of these commenters recommends amending the definition of "administrator" in proposed §7.1602(1) by deleting the sentence "The term includes administrator contractors and administrator subcontractors." Another commenter recommends that the Department amend the definition of "administrator" in proposed §7.1602(1) to state: "As defined in the Insurance Code §4151.001(1). For purposes of workers' compensation claims, an administrator is the person that has the authority to manage a claim payment account or fiduciary bank account or that has the management authority to oversee the adjusting and settling of claims on behalf of an insurer. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021." According to this commenter, the rules need to be clear regarding whether all ancillary service providers ("administrator subcontractors") who have a role in "adjusting" or "settling" a claim will be considered to be administrators, and thus apparently required to have written contracts with insurers or administrators, to obtain certificates of authority issued under proposed §7.1603(b), and to undergo on-sight audits under proposed §7.1611. Otherwise, the commenter contends, the range of "persons" that will be required under these rules to obtain a certificate of authority is exceedingly broad. The commenter further asserts that there is no public benefit in requiring subcontractors to obtain a certificate of authority, unless in fact an administrator subcontracts to another person the authority to manage a claim payment account or other fiduciary bank account or to manage and oversee the adjusting and settling of claims on behalf of an insurer. This commenter further contends that on-sight audits of these ancillary providers will add little value to the regulatory process and will be very costly.

Agency Response: The Department declines to make the requested changes for the following reasons.

Definitions of "administrator," "administrator contractor," and "administrator subcontractor" and use of these terms in the rules are not confusing, unclear, overly burdensome, overly broad, beyond the scope of Chapter 4151, or in excess of the Department's rulemaking authority. The Department disagrees that the definitions and use of the terms "administrator contractor" and "administrator subcontractor" in the rules, including in proposed §7.1602(1), (3) and (4), proposed §7.1603(b), and proposed §7.1611(g), are confusing, overly burdensome, or beyond the scope of the provisions of the Insurance Code Chapter 4151. The Department disagrees that the definition of "administrator" in proposed §7.1602(1), which includes administrator contractors and administrator subcontractors, exceeds the Department's rulemaking authority, is overly broad, or unclear. The Department understands that because HB 472 for the first time brings all workers' compensation administrators into the regulatory framework of Chapter 4151 and under the regulatory purview of the Department that initially the rules and the statute may appear confusing. However, when the rules are read in their entirety and in conjunction with Chapter 4151, the meaning and consistency of the terms "administrator," "administrator contractor," and "administrator subcontractor" with the statute become clear. The use and definitions of the terms "administrator," administrator contractor," and "administrator subcontractor" in these rules are applied consistently with the provisions of the Insurance Code Chapter 4151. The definition of the term "administrator" in §7.1602(1) is "as defined in the Insurance Code §4151.001(1). The term includes administrator contractors and administrator subcontractors. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021." The term "administrator contractor" is defined in §7.1602(3) as "an administrator as defined in the Insurance Code §4151.001(1) who contracts or enters into an agreement with an administrator subcontractor for the performance of all or a portion of the administrative services the administrator contractor previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021." The term "administrator subcontractor" is defined in §7.1602(4) as "an administrator as defined in the Insurance Code §4151.001(1) who contracts or enters into an agreement with an administrator contractor for the performance of all or a

portion of the administrative services the administrator contractor previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021." The definitions of the terms "administrator contractor" and "administrator subcontractor" in §7.1602(3) and (4) clarify that contractors or subcontractors who perform or offer to perform the acts of an administrator are also considered *administrators* for purposes of the Insurance Code Chapter 4151 and these rules. Therefore, if an administrator (Administrator A) contracts or enters into an agreement with another administrator (Administrator B), as that term is defined in the Insurance Code §4151.001(1) and §7.1602(1), to perform all or any part of the administrative services that Administrator A previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group, Administrator B is an "administrator subcontractor" as defined in §7.1602(4). Administrator A under this scenario would be considered an "administrator contractor" as defined in §7.1602(3). Therefore, under §7.1611(g), relating to operational review and on-site audit, an insurer may meet the requirements of §7.1611 for an administrator subcontractor (Administrator B) by reviewing and auditing the administrator contractor (Administrator A) only, provided that (i) the information supplied to the insurer by the administrator contractor (Administrator A) includes all necessary and relevant information relating to the administrator subcontractor (Administrator B); and (ii) no evidence of material non-compliance by the administrator subcontractor (Administrator B) exists. Also, under §7.1613(b), relating to written agreements between administrators and insurers, an administrator subcontractor (Administrator B) may meet the requirements of §7.1613 by entering into a written agreement with the administrator contractor (Administrator A) only, provided the written agreement meets the requirements of the Insurance Code Chapter 4151 and §7.1613, as applicable. Under §7.1615(e), relating to transfer of books and records, if a relationship between an administrator subcontractor (Administrator B) and an administrator contractor (Administrator A) terminates, the administrator subcontractor (Administrator B) may meet the requirements of §7.1615 by: (i) providing a complete and accurate original set or a complete and accurate copy or image of the original set of the insurer's, HMO's, plan sponsor's, or group's books and records to the administrator contractor (Administrator A); and (ii) providing written notice to the Department of the termination of the relationship or written agreement with the administrator contractor (Administrator A) no later than 30 days from the date the administrator subcontractor (Administrator B) first learns of the termination.

For the preceding reasons as well as the following reasons, the Department also disagrees that the definitions and use of the terms "administrator," "administrator contractor," and "administrator subcontractor" in the rules are overly burdensome or beyond the scope of the provisions of the Insurance Code Chapter 4151. The definitions in proposed §7.1602(1), (2), (3) and (4), which are adopted without changes, are consistent with the Department's rulemaking authorization in (i) §4151.006 to adopt rules that fairly, reasonably, and appropriately augment and implement the Insurance Code Chapter 4151, including rules to establish financial standards, reporting requirements, and required contract provisions; (ii) §4151.101(b) to adopt rules to prescribe provisions that must be included in the written agreement with an insurer or plan sponsor; (iii) §4151.103(d) to adopt rules to address the transfer of records from one administrator to another; and (iv) §4151.257 to adopt rules to implement the requirements of the Insurance Code Chapter 4151, Subchapter F, including rules prescribing requirements for contracts and master services agreements and requirements for the payment of claims. The definitions are consistent with the statutory provisions and general objectives of the Insurance Code Chapter 4151, including but not limited to §§4151.001, 4151.002, 4151.0021, 4151.006, 4151.051, and 4151.1042. For consistency with the statutory definition of "administrator" in §4151.001(1), the definitions of "administrator" in §7.1602(1), "administrator contractor" in §7.1602(3), and "administrator subcontractor" in §7.1602(4) reference the §4151.001(1) definition of the term "administrator." For consistency with the exemptions specified in §4151.002 and §4151.0021, the §7.1602(1), (3), and (4) definitions state that the term does not include a person described by the Insurance Code §4151.002 or §4151.0021. The definition in §7.1602(1) also clarifies that the term "administrator" includes "administrator contractors" and "administrator subcontractors," which are defined in §7.1601(3) and (4). This clarification is necessary because under Chapter 4151 persons who are administrators who contract out their administrative services that are subject to regulation under Chapter 4151 (administrator contractors) and persons who agree to perform such administrative services (administrator subcontractors), i.e., persons that act as or hold themselves out as administrators and meet the definition of "administrator" in §4151.001(1), are regulated pursuant to Chapter 4151 and these rules. The terms "administrator contractor" and "administrator subcontractor" are defined in §7.1601(3) and (4) to be an administrator as defined in the Insurance Code §4151.001(1) and a person not meeting an exemption described in §4151.002 or §4151.0021. Thus "administrator contractors" and "administrator subcontractors" are defined consistently with §4151.001(1), and therefore, necessarily must be regulated as administrators for purposes of Chapter 4151 and these rules. Additionally, neither the Insurance Code Chapter 4151 nor these rules prohibit the delegation of an administrative service from one administrator to another administrator or exclude contractors or subcontractors who act or hold themselves out as administrators, as that term is defined in §4151.001(1), from regulation under Chapter 4151. Because there are no statutory or regulatory prohibitions concerning the delegation of an administrative service, an administrator has the option to delegate the authority to perform some or all of its administrative services or functions to an administrator subcontractor. Accordingly, the Department has received questions about whether an administrator under the Insurance Code 4151 that subcontracts with another person to perform the services of an administrator as described in the Insurance Code §4151.001(1) is also considered an "administrator" under the Insurance Code Chapter 4151. Consequently, the Department has determined that it is necessary and appropriate to clarify the regulation of such persons under these rules. Since the Insurance Code Chapter 4151 (formerly Article 21.07-6), became effective on September 1, 1989, the Department has interpreted Chapter 4151 to mean that a person who contracts with a Chapter 4151 administrator to perform the services of the administrator as described in §4151.001(1), i.e., subcontractor, is also considered an "administrator" under the Insurance Code Chapter 4151. The definitions and use of the terms "administrator contractor" and "administrator subcontractor reflect the Department's long-standing practice and application of the definition of "administrator" in the Insurance Code §4151.001(1) in combination with the other provisions of Chapter 4151, including the exemptions enumerated in the Insurance Code §4151.002 and §4151.0021. Significantly, the Insurance Code §4151.051 expressly provides that "An individual, corporation, organization,

trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under this chapter." Therefore, an administrator contractor or administrator subcontractor as defined in §7.1602(3) and (4) that also is an individual, corporation, organization, trust, partnership, or other legal entity acting as or holding itself out as an administrator is required to have a certificate of authority issued under Chapter 4151. Because an administrator contractor or administrator subcontractor as defined in §7.1602(3) and (4) necessarily is considered an "administrator" under Chapter 4151 and the rules, an administrator contractor or administrator subcontractor is acting as an administrator, as contemplated under §4151.051. Accordingly, §7.1603(b) is necessary to clarify that both an administrator contractor and an administrator subcontractor are required to hold a certificate of authority under the Insurance Code Chapter 4151. Furthermore, if an individual, corporation, organization, trust, partnership, or other legal entity is holding itself out as an administrator contractor or administrator subcontractor as defined in §7.1602(3) and (4), this legal entity also is required to hold a certificate of authority under the Insurance Code Chapter 4151 and §7.1603(a).

In addition to the preceding reasons, the Department disagrees for the following additional reasons that the definition of "administrator" in proposed §7.1602(1), which includes administrator contractors and administrator subcontractors, exceeds the Department's rulemaking authority, is overly broad, or unclear. An analysis of the rule provisions in which the terms "administrator contractor" and "administrator subcontractor" are used and the applicable case law support this position. First, the inclusion of the terms do not impose any additional burdens, conditions, or restrictions on a person, including an administrator or insurer, beyond or inconsistent with the Insurance Code Chapter 4151. To the contrary, as previously stated, the terms "administrator," administrator contractor," and "administrator subcontractor" in these rules are applied consistently with the provisions of the Insurance Code Chapter 4151. These rule provisions are necessary to regulate persons that act or hold themselves out as administrators in situations where such persons further delegate the performance of an administrative service to another person acting or holding itself out as administrator as defined in Chapter 4151. Because the terms "administrator contractor" and "administrator subcontractor" are defined as administrators under §4151.001(1) and not persons described in the statutory exemptions enumerated in §4151.002 or §4151.0021, the terms are within the ambit of the term "administrator" in accordance with the provisions of Chapter 4151. In addition to §7.1601(1), (3), and (4) that define the terms "administrator," "administrative contractor," and "administrator subcontractor," the terms "administrative contractor" and "administrator subcontractor" as used in the rules implement the following statutory provisions: (i) in §7.1603(b), to clarify and implement the Insurance Code §4151.051(a), relating to the certificate of authority requirements, in situations where an administrative service or function is delegated from one administrator to another administrator; (ii) in §7.1611(g), to clarify and implement §4151.1042(c), relating to operational review and on-site audit, by permitting an insurer to meet the requirements of §7.1611 for an administrator subcontractor by reviewing and auditing the administrator contractor only, provided that certain specified conditions are met; (iii) in §7.1613(b), to clarify and implement §§4151.006, 4151.101, 4151.102, 4151.103, 4151.110, 4151.253, and 4151.257, relating to written agreements, by permitting an administrator subcontractor to meet the requirements of §7.1613 by entering into a written agreement with the administrator contractor only, provided the written agreement meets the requirements of the Insurance Code Chapter 4151 and §7.1613, as applicable; and (iv) in §7.1615(e), to clarify and implement §4151.112, relating to transfer of books and records, by permitting an administrator subcontractor to meet the requirements of §7.1615 by complying with certain specified requirements in situations in which the relationship between an administrator subcontractor and an administrator contractor terminates. Therefore, the rules are in accordance with the legal principle that rules promulgated by an administrative agency may not impose additional burdens, conditions, or restrictions beyond or inconsistent with the statutory provisions. (See *Hollywood Calling v. Public Utility Commission,* 805 S.W. 2d 618 (Tex. App--Austin, 1991 *no writ)).*

Second, Chapter 4151 of the Insurance Code grants broad rulemaking authority to the Department. Section 4151.006 authorizes the Commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement this chapter, including rules establishing financial standards, reporting requirements, and required contract provisions. Section 4151.101(b) authorizes the Commissioner by rule to prescribe provisions that must be included in the written agreement required between an administrator and insurer or plan sponsor under §4151.101. Section 4151.103(d) requires the Commissioner to adopt rules to address the transfer of records from one administrator to another. Section 4151.257 requires the Commissioner to adopt rules to implement the requirements of the Insurance Code Chapter 4151, Subchapter F (relating to workers' compensation benefit plans), including rules prescribing requirements for contracts and master services agreements and requirements for the payment of claims. The rules promulgated under §4151.257 must provide for compliance with the requirements of the Insurance Code Chapter 4151 for any contract that takes effect or has an annual anniversary date on or after January 1, 2008. These statutes expressly grant the Department broad authority to regulate all persons acting or holding themselves out as administrators as defined in Chapter 4151, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers compensation benefits, regardless of whether these persons are also contractors or subcontractors. Thus, the particular statutory rulemaking provisions, which provide broad authorization to the Department to promulgate rules (e.g., §4151.006 which authorizes the Commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement Chapter 4151, including rules establishing financial standards, reporting requirements, and required contract provisions), are a significant factor in determining whether the Department has exceeded its rulemaking authority. Additionally, the rule provisions relating to administrator contractors and administrator subcontractors clarify and implement the (i) certificate of authority requirements under §4151.051; (ii) notification and reporting requirements in §4151.052(b); (iii) written agreement or contracting requirements in §§4151.101, 4151.102, 4151.103(a), 4151.1042(a), 4151.110, and 4151.257; and (iv) oversight and monitoring requirements in §4151.1042. (See *Hollywood Calling at 620:* In making a determination as to whether a rule promulgated by an administrative agency exceeds the authority of the agency, the reviewing court must look not only to particular provisions to but all applicable provisions.)

Third, no provisions in the Insurance Code Chapter 4151 limit or restrict the Department's broad authority, powers, and duties to regulating only those persons acting or holding themselves out

as administrators who do not delegate the performance of an administrative service to another person acting or holding itself out as administrator as defined in Chapter 4151. Furthermore, as previously stated, no provisions in Chapter 4151, including the exemptions in §4151.002, prohibit the delegation of an administrative service from one administrator to another administrator or exclude contractors or subcontractors who act or hold themselves out as administrators, as that term is defined in Chapter 4151, from regulation under Chapter 4151 as administrators.

Fourth, moreover, the Department's positions and interpretations as previously described in this response are consistent with other case law interpreting an agency's administrative authority, including *Hammack v. Public Utility Commission of Texas,* 131 S.W. 3d 713, 723 (Tex. App.--Austin, 2004, no pet.) in which, according to the court "Because administrative agencies are given their statutory powers with a view to achieving legislative purposes more fully and effectively through the agency's specialized judgment, knowledge, and experience, the methods chosen by the agency, and its interpretation of the statute it is required to administer, are entitled to judicial respect." (emphasis added.) Also, according to *Gulf Coast Coalition of Cities v. Public Utilities Commission of Texas,* 161 S.W. 3d 706, 712 (Tex. App.--Austin 2005, no pet.), courts consider "the rule as a whole and in relationship to the statute which it implements. . . When there is . . . or room for policy determinations, the reviewing court defers to an administrative agency's interpretation unless it is plainly inconsistent with the language of the rule under review."

Fifth, therefore, not only are the rule provisions that define and use the terms "administrator contractor" or "administrator subcontractor" in harmony with, and not contrary to, the statutory provisions of the Insurance Code Chapter 4151, the use of these terms are also consistent with the general objectives of Chapter 4151, as amended by HB 472. According to the legislative bill analysis for HB 472, one of the main objectives is bring all workers' compensation administrators into the regulatory framework of Chapter 4151 and under the regulatory purview of the Department. (TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, Amended), HB 472, 80th Legislature, Regular Session (May 15, 2007)). To ensure that all such administrators, including contracting administrators (administrator contractors) and those they contract with (administrator subcontractors) that perform Chapter 4151 administrative functions are appropriately regulated under Chapter 4151, it is necessary to include such persons under the regulation of these rules. The inclusion of the terms "administrator contractor" and "administrator subcontractor" in the rules, including in the definition of "administrator in §7.1602(1), makes it absolutely clear that all administrators, including administrator contractors and administrator subcontractors, are required to comply with the requirements of the Insurance Code Chapter 4151 and the new rules and will ensure appropriate oversight and more efficient regulation of all administrators. Administrative agencies generally possess by implication such powers as may be necessary to effectuate the legislative objectives which underlie the administrative powers expressly conferred upon them. (See *Hammack* at 723.) This will assist in fulfilling the purpose to better protect the interests of the public and insurance consumers in this state.

Section 4151.002(14) does not require that the terms "administrator contractors" and "administrator subcontractors" be eliminated from the rules. The Department disagrees with the commenter that "administrator contractors" and "administrator subcontractors," as those terms are defined in proposed §7.1602(3) and (4), and adopted without change, fall within the exception of the Insurance Code §4151.002(14), and that as such, the definitions must be eliminated from the final rule. The Department does not agree that this is necessary because of the Government Code §311.011(a), which provides that words and phrases shall be read in context and construed according to the rules of grammar and common usage. It is the Department's position that administrator contractors and administrator subcontractors as defined in these rules do not fall within the exception of the Insurance Code §4151.002(14). To the contrary, the terms "administrator contractor" and "administrator subcontractor" are defined in §7.1602(3) and (4) necessarily to be "administrators" under the Insurance Code §4151.001(1) and to not be a person exempted by the Insurance Code §4151.0021 or §4151.002, including §4151.002(14). Thus, for a person to be considered an "administrator contractor" or an "administrator subcontractor" for purposes of Chapter 4151 and these rules, the person must meet these requirements. While it is possible that a particular entity or individual may be called a contractor or subcontractor in a context that is outside of the purview of these rules, the definitions in §7.1602(3) and (4) address only those contractors and subcontractors that are "administrator contractors" and "administrator subcontractors" for purposes of Chapter 4151 and these rules. Section 4151.002(14) provides that a person is not an administrator if the person provides technical, advisory, utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor but does not make any management or discretionary decisions on behalf of the insurer, plan, or plan sponsor. Whether a person is an administrator contractor or an administrator subcontractor as defined in §7.1602(3) or (4), or instead meets the §4151.002(14) exemption, depends entirely upon the particular facts and circumstances involved, including the functions or services the person performs or offers to perform and the particular arrangements or agreements entered into between the parties involved. Under these rules, the Department will continue, in accordance with its long-standing and existing application of the definition of "administrator" in the Insurance Code §4151.001(1) in combination with the other provisions of Chapter 4151, to make fact-specific determinations on a case-by-case basis regarding whether a particular person is an administrator contractor or an administrator subcontractor, considering such factors and circumstances as (i) the particular agreements or contracts entered into between the insurer, contractor, and/or subcontractor; (ii) the functions or services actually being performed or provided or offered to be performed or provided by the contractor and subcontractor; (e.g., whether either or both persons are collecting or offering to collect premiums or contributions from residents of this state, or adjusting, settling, or offering to adjust or settle claims for residents of this state, in connection with annuities or life, health, accident, pharmacy, or workers' compensation benefits); and (iii) whether the contractor and/or subcontractor meet an exemption under the Insurance Code §4151.002, including §4151.002(14).

Further, as previously stated in this response, because there is no statutory or regulatory prohibition concerning the delegation of an administrative service, an administrator contractor may choose to delegate the authority to perform some or all of its administrative services or functions to an administrator subcontractor. Also as previously stated, the delegated-to entity that is an individual, corporation, organization, trust, partnership, or other legal entity acting as or holding itself out as an administrator is required to have a certificate of authority issued under Chapter 4151. Therefore, in a situation where an "administrator," as defined in the Insurance Code §4151.001 and adopted

new §7.1602(1), delegates all or a portion of the administrative services or functions (e.g., collecting premium or contributions, or adjusting or settling claims) it previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group to another person meeting the definition of an administrator under the Insurance Code §4151.001(1) and new §7.1602(1), the delegating administrator is an "administrator contractor" and is so defined under adopted new §7.1602(3) while the administrator who is delegated to is an "administrator subcontractor" and is so defined under adopted new §7.1602(4). Because both persons in this scenario meet the definition of "administrator" in §4151.001(1) and the adopted new §7.1602(1), these persons by definition are not persons meeting one of the exemptions enumerated in the Insurance Code §4151.002 or §4151.0021. Under this scenario, because both the administrator contractor and administrator subcontractor qualify as an administrator under adopted new §7.1602(1), both are required to comply with the Insurance Code Chapter 4151 and these rules, including the requirement to obtain and hold a certificate of authority under Chapter 4151.

More complex scenarios are presented in the following two illustrations to further demonstrate the Department's position disagreeing with the commenter that the definitions of "contractor" and "subcontractor" must be eliminated from the final rule in order to give the exception in the Insurance Code §4151.002(14) its plain meaning. In Illustration A, an insurer (Insurer) enters an agreement with a person (Contractor No. 1) to delegate to Contractor No. 1 the discretionary or management authority to adjust or settle claims in connection with workers' compensation benefits for residents of this state. Contractor No. 1 further delegates the performance of adjusting the amount of workers' compensation medical benefits based upon a compensable injury to another person (Subcontractor No. 1) and further delegates the discretionary or management decision-making authority to Subcontractor No. 1 to adjust the amount of workers' compensation medical benefits based upon a compensable injury. Contractor No. 1 further delegates the performance of adjusting the compensability issues, including the extent of the compensable injury, to another person (Subcontractor No. 2) and further delegates the discretionary or management decision-making authority to Subcontractor No. 2 to adjust the compensability issues, including extent of the compensable injury. Subcontractor No. 1 adjusts the workers' compensation medical benefits using discretionary or management decision-making on behalf of the Insurer. Subcontractor No. 2 adjusts the compensability issues using discretionary or management decision-making on behalf of the Insurer. This scenario assumes that Contractor No. 1, Subcontractor No. 1, and Subcontractor No. 2 do not meet an exemption described in the Insurance Code §4151.002 or §4151.0021. Under this scenario, Contractor No. 1, Subcontractor No. 1, and Subcontractor No. 2 each meet the definition of an "administrator" under the Insurance Code §4151.001(1) and new §7.1602(1). Under §7.1601(3), Contractor No. 1 is also an "administrator contractor." Under §7.1601(4), Subcontractor No. 1 and Subcontractor No. 2 are both "administrator subcontractors." Additionally, under these particular circumstances, all three persons are subject to the requirements of the Insurance Code Chapter 4151 and these rules, including the requirement to hold a certificate of authority under the Insurance Code 4151 and new §7.1603.

In Illustration B, there is the same hypothetical situation as in Illustration A, except that Subcontractor No. 1 is not delegated either discretionary or management decision-making authority to adjust the workers' compensation medical benefits, and never adjusts or settles claims, collects premiums or contributions, or holds itself out as, adjusting or settling claims or collecting premiums or contributions for residents in this state in connection with life and annuity, accident, health, pharmacy, or workers' compensation benefits. Additionally, Subcontractor No. 1 only provides technical, advisory, utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor but does not make any management or discretionary decisions on behalf of the insurer, plan, or plan sponsor in the manner contemplated under the Insurance Code §4151.002(14). Under these particular circumstances in Illustration B, Subcontractor No. 1 does not meet the definition of "administrator" under the Insurance Code §4151.001(1), and therefore, is not an "administrator" under the Insurance Code §4151 or these rules. Subcontractor No. 1 is also not an "administrator subcontractor" under new §7.1602(4).

Department did not state or imply that "administrator contractors" and "administrator subcontractors," as defined in §7.1602(3) and (4) fall within the exception of the Insurance Code §4151.002(14). The Department disagrees that it at any time stated or implied agreement with the commenter's assertion that "administrator contractors" and "administrator subcontractors," as defined in §7.1602(3) and (4), fall within the exception of the Insurance Code §4151.002(14). On page 33 of 158 of the Department's proposal published in the *Texas Register* on December 5, 2008, the Department did not state or imply, as the commenter contends, that the administrator, on behalf of the insurer, is ultimately responsible for making the management and discretionary decisions. Rather, the Department stated that each *"insurer"* retains the ultimate responsibility for all of its delegated duties, regardless of whether they are performed by an administrator contractor or an administrator subcontractor. The page 33 discussion provides the background behind the Department's long standing position that a person that functions as an administrator in a manner that is required to obtain a certificate of authority under the Insurance Code Chapter 4151 must obtain such a certificate of authority, regardless of whether that person is in a direct contractual relationship with an insurer or is a down-stream subcontractor who is delegated administrator functions from another administrator. Page 33 of 158 of the preamble of the proposed rules explains in pertinent part: "However, an administrator contractor *may* delegate a few, specific duties to an administrator subcontractor and *may* retain a contractual responsibility for the performance of those duties, despite the delegation of those duties to the administrator subcontractor. Additionally, some insurers *may* permit their administrator contractors to further delegate duties to administrator subcontractors, provided that the administrator contractors retain responsibility for the performance of those duties. As previously stated, each *insurer* retains the ultimate responsibility for all of its delegated duties, regardless of whether they are performed by an administrator contractor or an administrator subcontractor." (emphasis added) These explanations, which are made in the context of the contractual requirements mandated in §7.1613, illustrate just a few of the many possible variations that may exist among insurers, administrator contractors, and administrator subcontractors concerning contractual arrangements, and the scope of duties, responsibilities, and authority delegated (e.g., extent of delegated management or discretionary authority). Additionally, the Insurance Code §4151.1042(a) does not state or imply that "administrator contractors" or "administrator subcontractors," as those terms are defined in §7.1601, fall within the exception of the Insurance Code §4151.002(14). Nor does the Insurance Code §4151.1042(a) state or imply that an administrator, on

behalf of the insurer, is ultimately responsible for making the management and discretionary decisions. Instead, the Insurance Code §4151.1042(a) sets forth the responsibilities of an insurer if it uses the services of an administrator, as defined in the Insurance Code §4151.001(1). Specifically, §4151.1042(a) provides that "If an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, reimbursement procedures, and claims payment procedures applicable to the coverage and for securing reinsurance, if any. The insurer shall provide a copy of the written requirements relating to those matters to the administrator. The responsibilities of the administrator as to any of those matters must be set forth in the written agreement between the administrator and the insurer."

Definition of "administrator" in the Insurance Code §4151.001(1) does not only include or define two types of delegated entities. The Department does not agree that the definition of "administrator" in the Insurance Code §4151.001(1) only includes or defines two types of delegated entities to which the provision applies (delegated entities under the Insurance Code Chapter 1272 and certified workers' compensation networks under the Insurance Code Chapter 1305). This comment is based on the sentence in the Insurance Code §4151.001(1) that states "The term includes a delegated entity under Chapter 1272 and a workers' compensation health care network authorized under Chapter 1305 that administers a workers' compensation claim for an insurer, ..." This sentence does not, as the commenter contends, limit the definition of "administrator" to only the two types of entities listed, nor exclude all other "administrator contractors" or "administrator subcontractors" that are not one of these listed entities. Under the commenter's reasoning, the only persons that could ever meet the definition of "administrator" in the Insurance Code §4151.001(1) would be a delegated entity under the Insurance Code Chapter 1272 or a workers' compensation health care network authorized under the Insurance Code Chapter 1305. This interpretation is not valid for several reasons. First, this construction is not consistent with the objectives of HB 472 as explained in the legislative bill analysis for HB 472. According to the bill analysis, one of the main objectives is to include workers' compensation administrators into the regulatory framework of Chapter 4151 and under the regulatory purview of the Department. (TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, Amended), HB 472, 80th Legislature, Regular Session (May 15, 2007)). This language clearly intends that more than just workers' compensation networks authorized under the Insurance Code Chapter 1305 constitute the total extent of the objective. Secondly, a plain reading of the Insurance Code Chapter 4151, as amended by HB 472, does not support this reasoning. For example, it is not reasonable that the definition of "administrator" in the Insurance Code §4151.001(1) when read in conjunction with other provisions of Chapter 4151, limit the definition of administrator to only the two types listed by the commenter.

Department did not represent that the intent is to regulate only someone performing an adjusting function. The Department disagrees that it stated or implied in a November 4, 2008 meeting (or at any other time) that it is the Department's intent to regulate only those performing an adjusting function and thereby confirmed that the Department does not intend to regulate contractors and subcontractors. Instead, Department staff stated in that meeting that the Department is not looking at requiring certificates of authority to act as administrators from persons in the workers' compensation business unless the persons are performing the acts of an administrator or holding themselves out as administrators. For example, §4151.051(a) prohibits any individual, corporation, organization, trust, partnership, or other legal entity from acting or holding itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under Chapter 4151. Clearly, the broad language of §4151.051(a) cannot be interpreted to limit the definition of administrator to only the two types listed by the commenter. Also, §4151.151 contemplates a "pharmacy benefit manager" as another type of delegated entity that is an administrator for purposes of the Insurance Code Chapter 4151. Thirdly, the commenter's interpretation ignores the first sentence in §4151.001(1) and the use of the word "person" in that sentence. The first sentence states that "Administrator" means "a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state." The Insurance Code §4151.001(3) defines the term "person" very broadly as "an individual, partnership, corporation, organization, government or governmental subdivision or agency, business trust, estate trust, association, or any other legal entity." Therefore, the definition of "administrator" in §4151.001(1) must encompass more than just "a delegated entity under Chapter 1272 and a workers' compensation health care network authorized under Chapter 1305 that administers a workers' compensation claim for an insurer." It is not reasonable that the second sentence in §4151.001(1) that the commenter relies on renders the first sentence meaningless. The fourth reason is that the use of the term "includes" is a term of enlargement and not of limitation. For example, see Government Code §311.005(13), which defines the terms "includes" and "including," and Jackson v. Chappell, 37 S.W. 3d 15, 25-26 (Tex. App.--Tyler, 2000, no pet.) holding that "Construing the statute with the aid of the Code Construction Act, "includes" and "including" are "terms of enlargement and not of limitation or exclusive enumeration, and use of the terms does not create a presumption that components not expressed are excluded." Therefore, the use of the term "includes" in the second sentence in §4151.001(1) cannot be interpreted to exclude other persons that are not expressed.

Definition of "Administrative Services" in §7.1602(2)

Comment: One commenter objects to the definition of "administrative services" in proposed §7.1602(2) because the definition is overly broad. The commenter recommends revising the definition of "administrative services" to read: "Claims management and adjudication services offered or performed by an administrator."

Agency Response. The Department disagrees that the term "administrative services" in §7.1602(2) is overly broad and declines to adopt the commenter's suggested change. The commenter's recommendation to replace the proposed definition for "administrative services" in §7.1602(2) to read "Claims management and adjudication services offered or performed by an administrator" is not consistent with the definition of "Administrator" in §4151.001(1) of the Insurance Code. Section 4151.001(1) defines the term "Administrator" to mean a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Section 7.1602(2), which is adopted without change to the proposed text, defines "administrative services" to mean "Services offered or performed by an administrator." This definition in §7.1602(2) is consistent with the

definition of "Administrator" in §4151.001(1) and is therefore the more appropriate definition for the purposes of these rules. The additional reasons for the Department's disagreement with the commenter are the following. First, the term "administrative services" as used in these rules simply refers to an administrator's functions in a generic sense. Second, an analysis of the rule provisions in which the term is used indicates that the term does not impose any additional burdens, restrictions, conditions, or requirements on a person who is an administrator that is in addition to those functions which the administrator has agreed to perform. These rule provisions that use the term "administrative services" are (i) §7.1601(b) to clarify the scope of the rules to require, in accordance with the Insurance Code §1272.058 and the Labor Code §407A.009, an administrator performing administrative services on behalf of an HMO or a workers' compensation self-insurance group to meet the same requirements under the Insurance Code Chapter 4151 and this subchapter as an administrator performing administrative services on behalf of an insurer or plan sponsor; (ii) §7.1601(3) and (4) to define the terms "administrative contractor" and "administrator subcontractor"; (iii) §7.1602(15) to define the term "master services agreement"; (iv) §7.1609(d) to describe those who are exempt from audit report requirements specified in §7.1609(c); (v) §7.1613 to clarify the requirements for written agreements between administrators and insurers; (vi) §7.1614(5) to prohibit, pursuant to the Labor Code §415.0036, an administrator from offering to pay, paying, soliciting, or receiving an improper inducement relating to the delivery of benefits to an injured employee, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state; and (vii) §7.1614(6) to prohibit, pursuant to the Labor Code §415.0036, an administrator from improperly attempting to influence the delivery of benefits to an injured employee, including through the making of improper threats, if the administrator performs administrative services on behalf of a person who is a participant in the workers' compensation system of this state.

§7.1602(6). Definition of "Claim"

Comment: Two commenters object to the definition of "Claim" in proposed §7.1602(6) because it is unclear or overly broad for purposes of workers' compensation insurance. One commenter requests that the proposed definition be revised to read: "A demand for payment, services, or benefits under a plan. For the purposes of workers' compensation insurance, a claim is established when a loss occurs on a specific date of injury. A separate workers' compensation claim shall not be deemed to have occurred or been established when a claims action occurs within a claim established for a specific date of injury." The other commenter similarly recommends that there should be only one "claim" for workers' compensation purposes and should be limited to a report of an injury to an insurance carrier under the Labor Code §409.021. This second commenter recommends the definition be revised to state: "A demand for payment, services, or benefits under a plan. A claim for workers' compensation purposes is a report of injury under §409.021 of the Labor Code." The commenters' reason for the requested changes is that the proposed definition does not take into account that in the Texas workers' compensation system, a claim is established when a loss occurs on a specific date known as the "date of injury," and not for each claim transaction that occurs during the "life" of a workers' compensation claim. The commenters contend that the definition in proposed §7.1602(6) would result in every actionable development in a workers' compensation claim being considered a "claim." According to the commenters, these actionable developments include every medical bill and income benefit, every attorney fee order, every decision and order of the DWC, and even billings submitted by the DWC to carriers for performing audits.

Agency Response: The Department disagrees and declines to make the recommended changes. The Department understands that the written notice of injury to a carrier under Labor Code §409.021(a) begins the process of payment of benefits under the Texas Workers' Compensation Act. However, one of the purposes of the definition of "Claim" in §7.1602(6) is to make it absolutely clear that each demand for payment, service, or benefit under a plan to provide workers' compensation benefits is considered a claim for purposes of these rules. The Department disagrees with the commenters for the following reasons. First, the term "Claim" is defined in §7.1602(6) to apply to adjusting or settling claims in connection with all types of insurance benefits contemplated under the Insurance Code §4151.001(1)--annuities, life benefits, health benefits, accident benefits, pharmacy benefits, and workers' compensation benefits. Section 4151.001(1) provides in pertinent part that "Administrator" means a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Thus, the definition is consistent with the Insurance Code §4151.001(1). Second, the definition of "Claim" in §7.1602(6) is necessary to clarify that a person adjusting or settling any of the individual components involved in determining or paying workers' compensation benefits, including, but not limited to, a medical benefit, a temporary income benefit, a supplemental income benefit, a death benefit, a burial benefit, or the compensability of the injury, is within the ambit of the definition of "Administrator" in the Insurance Code §4151.001(1). While the filing of single written notice of injury triggers the process of payment of benefits under the Texas Workers' Compensation Act, the subsequent adjusting or settling functions can involve multiple and periodic demands for payment, service, or benefit, and multiple and periodic payments of medical benefits, income benefits, etc. As previously stated, the definition of "Claim" in §7.1602(6) makes it absolutely clear that each demand for payment, service, or benefit under a plan to provide workers' compensation benefits is considered a claim for purposes of these rules. Therefore, a person adjusting or settling any of the individual components involved in determining or paying workers' compensation benefits is regulated as an administrator under the rules, unless the person qualifies for an exemption under Chapter 4151, including §4151.002 or §4151.0021. Third, this concept is not unique to workers' compensation. Rather, it has been the Department's long-standing practice to apply this concept to other types of insurance, such as group health coverage, individual health coverage, or coverage provided by health maintenance organizations, for purposes of regulating administrators under the Insurance Code Chapter 4151. Fourth, the commenters' suggested revisions to the definition may conflict with the overall objective and intent of HB 472, which expanded the application of Chapter 4151 to persons performing or offering to perform administrative services in connection with workers' compensation benefits in this state. It is the Department's position that, at a minimum, an administrator subject to Chapter 4151 includes a person that has been delegated by an insurer, group, plan, or plan sponsor, the on-going management of or on-going discretionary decision-making authority to perform claim adjusting or settlement functions. Adoption of either of the commenters' suggestions, however, could result in a person that is delegated these types of functions after an in-

jury is reported to a carrier under the Labor Code §409.021 being exempt from the rules. This could be the case even if that person made multiple and periodic payments for medical benefits, income benefits, etc. after the date the carrier receives the written notice of injury under §409.021. The Department's position is that such a result would conflict with the legislative intent and general objectives of HB 472 and the Insurance Code Chapter 4151.

§7.1602(8) and §7.1612. Fiduciary Bank Account

Comment: One commenter objects to the definition of "Fiduciary bank account" in proposed §7.1602(8) because the definition does not take into account the difference between premium funds and funds reserved for the payment of benefits and claims expenses. This commenter recommends that the proposed definition be revised to read: "An account used to hold premium collected by an administrator on behalf of an insurer or self-insured. This term does not include an account used to pay claims benefits and claims expenses." In a related comment, another commenter suggests that the Department include a new definition for "Claim payment account" such as "An account used to hold funds for the payment of benefits and claim expenses." Both commenters state that few if any workers' compensation administrators "ever touch a premium." Rather, workers' compensation administrators set up and control bank accounts that are funded by a carrier or self-insured for the payment of claims. Another commenter recommends that proposed §7.1612 be modified to clarify that it does not apply to loss fund accounts. This commenter states that proposed §7.1612 applies to fiduciary bank accounts for premiums collected by administrators, and that some administrators do not collect premium but do hold loss fund accounts funded by the insurer to pay administered claims.

Agency Response: The Department does not agree that these changes are necessary at this time and declines to make the recommended changes. The term "Fiduciary bank account" is clearly defined in §7.1602(8), which is adopted without change, as "An account used to hold a premium." As observed by one commenter, proposed §7.1612 applies to fiduciary bank accounts for premiums collected by administrators. This definition is consistent with the Insurance Code §§4151.001(1) and 4151.105 - 4151.108 relating to an administrator's collection of premiums or contributions on behalf of an insurer, plan, or plan sponsor, or return premiums and return contributions (which function the same as return premiums but are administered by certain self-insurers) an administrator receives from an insurer, plan, or plan sponsor. Section 7.1612, in conjunction with the definitions of "Premium" and "Fiduciary bank account" in §7.1602(8) and (19), prescribes the general requirements related to the establishment and maintenance of fiduciary accounts used to hold premiums collected or received by administrators, including ensuring that all premiums are maintained by administrators in fiduciary accounts that are separate and distinguishable from any account used by an administrator to pay a claim on behalf of an insurer, HMO, plan sponsor, or group. Accordingly, §7.1612(i) prohibits an administrator from paying a claim from a fiduciary bank account. This is consistent with the statutory prohibition in the Insurance Code §4151.109. Section 4151.109 provides that an administrator may not pay a claim from a fiduciary bank account established under §4151.107. Further, the Insurance Code §4151.108(3) lists the transfer to and deposit in a claims payment account for payment of a claim as provided by §4151.111 as one of seven purposes for which a withdrawal can be made from a fiduciary bank account holding premium. The Department understands that there is a difference between a fiduciary bank account used to hold premium and a "loss fund account," referred to as a "claims payment account" in the Insurance Code §4151.108. Regarding the comments that few if any workers' compensation administrators "ever touch a premium," the Department is aware of administrators that do in fact administer workers' compensation premiums, such as administrators that provide the day-to-day management of workers' compensation self-insurance groups. If an administrator does not collect or receive premiums, the definition of the term "Fiduciary bank account" and rule provisions relating to fiduciary bank accounts do not apply. However, while not expressly required by these rules, the Department believes that it is a prudent business practice for insurers, HMOs, groups, plans, or plan sponsors to set up accounts for the payment of claims that include appropriate safe-guards and controls, such as those required in §7.1612 for establishing fiduciary bank accounts. It is also important that these safe-guards and controls otherwise comply with applicable state or federal laws, including, but not limited to, the Insurance Code §§4151.1042(a), 4151.105(a)(2) and (b), 4151.108(3), 4151.109, 4151.111, 4151.117, 4151.255, 4151.256, and 4151.257; and these rules, including §§7.1611(d) and (e), 7.1613(d), and 7.1616(a)(8). Sections 7.1611(d) and (e) and 7.1613(d) address the monitoring and oversight of administrators with regard to claims adjustment or claims settlement. Section 7.1611(d) and (e) prescribe the minimum information that an insurer should review during the required review or on-site audit. This includes a review of an administrator's compliance with the contract between the administrator and the insurer and the administrator's performance of claims adjudication and payment. Section 7.1613(d) requires a written agreement entered into under §7.1613 to include: (i) a requirement that an administrator comply with the requirements of the Insurance Code, the Labor Code, and rules adopted thereunder, including holding appropriate authorizations; (ii) a description of the administrative services the administrator is expected to provide and any applicable instructions related to the performance of those services, including references to an insurer's claims handling practices or procedures; (iii) a provision relating to the continuity of services and addressing the obligations of the administrator and the insurer under §7.1615 (relating to Transfer of Books and Records), including the method and manner in which the insurer and administrator will meet those requirements; and (iv) a provision addressing an insurer's obligation to review and audit the performance of its administrators under §7.1611 (relating to Operational Review and On-Site Audit), including the method and manner in which the insurer will meet those requirements. Further, §7.1616(a)(8) provides that an applicant or administrator that has engaged or is engaged in a pattern of failing to settle claims in accordance with contractual, regulatory, or statutory requirements may indicate that an applicant or administrator is operating or conducting business in a potentially hazardous or injurious manner.

§7.1602(17) and §7.1602(18). Definition of "Plan" and "Plan sponsor"

Comment: Three commenters object to the definition of "Plan" in proposed §7.1602(17), and one of these commenters also objects to the definition of "Plan sponsor" in proposed §7.1602(18). According to one commenter, the definition of "Plan" does not follow the definition of "Plan" in the Insurance Code §4151.001(4), and the Department does not have the authority to modify or amend the statutory definition of the term through rulemaking; the commenter cites case law to support this assertion *(Cruse*

v. Texas Department of Transportation, 2007 WL 1345433 (Tex. App.--Amarillo May 8, 2007, no pet.) and *Hollywood Calling v. Public Utility Commission,* 805 SW 2d 618 (Tex. App--1991)). This commenter recommends that the Department revise the definition of "Plan" in proposed §7.1602(17) to state: "As defined in the Insurance Code §4151.001(4)." According to a second commenter, the definition of "Plan" is too broad, and could include non-subscriber plans for workers' compensation and occupational accident coverage for independent contractors. This commenter requests an explicit exemption for non-subscriber plans from the definition of "Plan" in §7.1602(17). The third commenter states that the proposed definitions of "Plan" and "Plan sponsor" add the concept of funds and programs that provide workers' compensation benefits, although the Insurance Code §4151.001(4) does not mention workers' compensation. According to this commenter, the proposed definition of "Plan" greatly expands the statutory definition. Additionally, the commenter objects to the proposed definition of "Plan" because it adds "Pharmacy benefit" to the statutory definition of "Plan."

Agency Response: The Department disagrees and declines to adopt the commenters' suggested changes. For the following reasons, the Department disagrees that because the definition of the term "Plan" in proposed §7.1602(17) is not exactly the same as the definition of the term "Plan" in the Insurance Code §4151.001(4), the term "Plan" in proposed §7.1602(17) is inconsistent with the statutory definition and the Department exceeded its rulemaking authority. An analysis of the rule provisions in which the term "Plan" is used and the applicable case law supports the Department's position. First, the term as defined in §7.1602(17) does not impose any additional burdens, conditions, or restrictions on a person beyond or inconsistent with the Insurance Code Chapter 4151. To the contrary, the definitions in proposed §7.1602(17) and (18), which are adopted without changes, are necessary to clarify that the term "Plan" for purposes of the rules may include a plan for pharmacy benefits or for workers' compensation benefits. The addition of workers' compensation benefits and pharmacy benefits to the definition of the term "Plan" in §7.1602(17) is consistent with the provisions and general objectives of the Insurance Code Chapter 4151. Section 4151.001(1) provides in pertinent part that "Administrator" means a person who, in connection with annuities or life benefits, health benefits, accident benefits, pharmacy benefits, or workers' compensation benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. Because §4151.001(1) explicitly provides for the regulation of administrators providing administrative services or functions in connection with pharmacy benefits or workers' compensation benefits, it is necessary to define the term "Plan" to include these services or functions. Failure to clarify that the definition of "Plan" in §7.1602(17) includes "pharmacy benefits" and "workers' compensation benefits" would create a conflict with §4151.001(1) and result in unnecessary ambiguity because of the inconsistency between the rules and §4151.001(1). This ambiguity could result in compliance and enforcement difficulties. The definitions of "Plan" and "Plan Sponsor" in §7.1602(17) and (18) and use of the term "Plan sponsor" in the rules, including in §7.1612(b), (f)(2), and (g) and §7.1615(a), (d), and (e), are necessary to clarify and implement various provisions of the Insurance Code Chapter 4151, including §4151.103(d), which requires the Department to adopt rules to address the transfer of records from one administrator to another; and §§4151.106 - 4151.109, which address the fiduciary duties of administrators that collect premiums on behalf of an insurer, HMO, plan sponsor, or group. Therefore, the definition of "Plan" is in accordance with the legal principles that (i) rules promulgated by an administrative agency may not impose additional burdens, conditions, or restrictions beyond or inconsistent with the statutory provisions; and (ii) in making a determination as to whether a rule promulgated by an administrative agency exceeds the authority of the agency, the reviewing court must look not only to particular provisions but to all applicable provisions. (See *Hollywood Calling v. Public Utility Commission,* 805 S.W. 2d 618 (Tex. App--Austin, 1991 *no writ)).* Second, Chapter 4151 of the Insurance Code grants broad rulemaking authority to the Department. Section 4151.006 authorizes the Commissioner to adopt rules that are fair, reasonable, and appropriate to augment and implement this chapter, including rules establishing financial standards, reporting requirements, and required contract provisions. The term "Plan" is used in the rules to define the term "Claim" in §7.1602(6). The use of the terms "Plan" and "Claim" in the rules is authorized by and is consistent with the Department's broad rulemaking authorization in the Insurance Code §4151.006. Thus, the particular statutory rulemaking provisions, which provide broad authorization to the Department to promulgate rules, are a significant factor in determining whether the Department has exceeded its rulemaking authority. Third, not only are the rule provisions that define and use the terms "Plan" and "Plan sponsor" in harmony with, and not contrary to, the statutory provisions of the Insurance Code Chapter 4151, the use of these terms are also consistent with the general objectives of Chapter 4151, as amended by HB 472. According to the legislative bill analysis for HB 472, one of the main objectives is to include all workers' compensation administrators into the regulatory framework of Chapter 4151 and under the regulatory purview of the Department. (Texas Senate State Affairs Committee, Bill Analysis (Committee Report, Amended), HB 472, 80th Legislature, Regular Session (May 15, 2007)). To ensure that all "Plans" and "Plan sponsors," including those in connection with pharmacy benefits or workers' compensation benefits as required under §4151.001(1) are appropriately regulated under Chapter 4151, it is necessary to include these types of plans in the definition of "Plan." Administrative agencies generally possess by implication such powers as may be necessary to effectuate the legislative objectives which underlie the administrative powers expressly conferred upon them. (See *Hammack v. Public Utility Commission of Texas, 131 S.W. 3d 713, 723 (Tex. App.--Austin, 2004, no pet.))*

Additionally, the Department disagrees that the definition of "Plan" in §7.1602(17) is too broad because it could include non-subscriber plans for workers' compensation and occupational accident coverage for independent contractors. Non-subscriber plans may be offered by employers that do not subscribe to the workers' compensation system. In lieu of workers' compensation insurance, these employers may offer their employees different types of insurance coverage or benefits that may include lines of insurance subject to Chapter 4151 such as health, accident, and health benefits coverage. If a person acts or holds itself out as an administrator, as defined in §4151.001(1), for a non-subscriber plan that provides health, accident, health benefits, or any line of insurance subject to Chapter 4151 to residents in this state, the person is subject to the requirements of the Insurance Code Chapter 4151 and the rules, including the requirement to obtain an administrator certificate of authority, unless the persons meet an exemption under §4151.002 or §4151.0021. Additionally, an administrator administering a plan that is exempt from state regulation under the federal Employee Retirement Income Security Act (ERISA) for a non-subscriber that provides benefits for a work-re-

lated injury is not subject to the provisions of the Insurance Code Chapter 4151 or these rules for that plan. Accordingly, §7.1601(d) clarifies that the proposed new subchapter does not apply to a person acting as or holding itself out as an administrator for an ERISA qualified employee welfare benefit plan that is exempt from regulation by this state with respect to that particular employee welfare benefit plan.

§7.1602(19). Definition of "Premium"

Comment: Two commenters object to the definition of "Premium" in proposed §7.1602(19). One commenter states that the proposed definition of "Premium" includes the term "premium" itself to define the term and needs to be clarified to better describe what the term "Premium" means for purposes of the third-party administrator rules. This commenter recommends that the definition of the term "Premium" be revised to read: "Payments made to an insurance company to cover the cost of insurance for a certain level of insurance coverage for a specified period of time. For purposes of the subtitle, the term may include contribution, return premium, and return contribution." According to the other commenter, the inclusion of the word "contributions" within the definition of "Premium" in proposed §7.1602(19) is unclear. This commenter states that although it can conceive of no possible way that funds used to pay claims could be considered "premium" funds, the final rule needs to contain a statement within the definition that "payments and funds used to pay claims are not within this definition of premiums."

Agency Response: The Department disagrees and declines to make the recommended changes to the definition of "Premium." The Department believes that the definition of "Premium" in proposed §7.1602(19), which is adopted without changes, is clear and complete for the following reasons. First, the term "Premium" is defined to include all of the types of funds that are collected on behalf of or received from an insurer, HMO, plan sponsor, or group. Such funds are collected for purposes related to insurance coverage and related benefits as contemplated under the Insurance Code 4151, including §4151.001(1) and §§4151.105 - 4151.108. As used in §7.1602(19) and the Insurance Code Chapter 4151, "Premium" and "contribution" refer to funds collected by an administrator on behalf of an insurer, HMO, plan sponsor, or group for insurance coverage providing annuities, health, accident, life, pharmacy, or workers' compensation benefits. As used in §7.1602(19) and the Insurance Code Chapter 4151, "return premium" and "return contribution" refer to funds received by an administrator from an insurer, HMO, plan sponsor, or group that are to be returned to an insured or plan participant under certain circumstances, e.g., upon the cancellation of a policy. Section 4151.001(1), relating to definition of "administrator," refers to "premiums and contributions"; §4151.105, relating to payments to administrator, refers to a "premium" or "contribution" and a "return premium" or "contribution"; §4151.106, relating to certain funds collected or received by administrator, refers to "any premium or contribution" and "a return premium"; §4151.107, relating to delivery or deposit of certain funds received by the administrator, refers to "a premium, contribution, or return premium"; and §4151.108, relating to withdrawals from fiduciary bank accounts, refers to a "return premium." Second, although the term "return contributions" is not explicitly referenced in Chapter 4151, §4151.105(a) and §4151.107 contemplate an administrator receiving not only return premiums from an insurer, plan, or plan sponsor, but also the return of all or a portion of a contribution previously paid by an insured or plan participant. Thus, inclusion of the term "return contribution" in the definition of "Premium" is necessary to include all possible types of funds and to thereby clarify that a return payment of all or a portion of the contribution to an administrator for delivery to an insured or plan participant is a type of fund subject to the fiduciary bank account requirements specified in Chapter 4151 and these rules. Third, the definition of "Premium" in §7.1602(19), in conjunction with §7.1611, relating to operational review and on-site audit, is necessary to implement the fiduciary duty and fiduciary bank account requirements in the Insurance Code §§4151.106 - 4151.109. Section 4151.106 provides that an administrator holds a premium, contribution, or return premium in a fiduciary capacity. To implement this fiduciary requirement, §7.1612, relating to fiduciary bank accounts, requires an administrator to hold all premium, as defined in §7.1602(19), in a fiduciary capacity. Section 7.1612 prescribes the general requirements related to the establishment and maintenance of fiduciary accounts used to hold collected premiums, as defined in §7.1602(19). Section 7.1612(g) requires an administrator to provide a copy of the records relating to the account activity of an insurer, HMO, plan sponsor, or group in a fiduciary bank account to the insurer, HMO, plan sponsor, or group, upon its reasonable request. The purpose of §7.1612(g) is to enable the insurer, HMO, plan sponsor, or group to properly oversee the activities of the administrator and to ensure that the premiums collected on its behalf are properly accounted for and maintained.

The Department also disagrees with the recommendation to include a statement in the definition of "Premium" to provide that "payments and funds used to pay claims are not within this definition of premiums." The Department believes that it is not necessary to add this language in order to specify the proper scope and applicability of the rules and believes that to do so, could result in unnecessary ambiguity. First, as previously stated, the rules in §§7.1601, 7.1611, and 7.1612 clearly and appropriately incorporate the terms "premium," "contribution," and "return premium," as used in the Insurance Code Chapter 4151, including in the definition of the term "administrator" in §4151.001(1) and in §§4151.105 - 4151.108. For example, §7.1612 prescribes the general requirements related to the establishment and maintenance of fiduciary accounts used to hold premiums collected or received by administrators, including ensuring that all premiums are maintained by administrators in fiduciary accounts that are separate and distinguishable from any account used by an administrator to pay a claim on behalf of an insurer, HMO, plan sponsor, or group. Accordingly, §7.1612(i) prohibits an administrator from paying a claim from a fiduciary bank account; this is consistent with the statutory prohibition in the Insurance Code §4151.109. Furthermore, when read in context with the provisions of §§4151.105 - 4151.108 and §4151.111, the terms "premium," "contribution," "return premium," and "return contribution" as used in these rules are clearly distinguishable from funds deposited in a "claims payment account," which are used for payment of a claim as provided by §4151.108(3) and §4151.111. The Insurance Code Chapter 4151 references the term "claims payment account" in §4151.108(3) and states in §4151.111(b) that "The administrator shall pay each claim on a draft authorized by the insurer, plan, or plan sponsor in the written agreement." However, Chapter 4151 does not define the term "claims payment account" nor does it use the phrase suggested by the commenter, "payments and funds used to pay claims are not within this definition of premiums." Second, prior to the enactment of HB 472 and in the context of life, health and annuities business, the Department has had experience distinguishing between a "fiduciary bank account" established to hold premium and a "claims payment account." The Department has not encountered any problems or difficulties in making this distinction.

The Department's experience demonstrates that it is necessary to conduct a fact-specific, case-by-case analysis to determine (i) whether a particular account falls within the meaning of the statutory terms "fiduciary bank account" or "claims payment account for payment of a claim as provided by §4151.111" and (ii) whether particular funds fall within the meaning of the statutory terms "premium," "contribution," or "return premium."

§7.1604(e). Application for Certificate of Authority: Other Information Required

Comment: One commenter objects to proposed §7.1604(e) as overly broad and giving the Commissioner unlimited authority to request any information deemed appropriate whether the information is or is not related to issues, facts, or circumstances germane to whether or not an application for a certificate of authority should be approved. The commenter requests that the Department revise §7.1604(e) to require that any additional information deemed by the Commissioner to be required must be reasonably required in keeping with the standard established in HB 472 to adopt rules that are fair, reasonable and appropriate to augment and implement the Insurance Code Chapter 4151.

Agency Response: The Department disagrees and declines to make the commenter's suggested changes. Proposed §7.1604(e), which is adopted without change, states that "Pursuant to the Insurance Code §4151.052(a)(5), the commissioner may require the submission of any other information the commissioner reasonably requires in determining whether to approve or disapprove an application for a certificate of authority." As indicated in the rule provision, this requirement is consistent with the Insurance Code §4151.052(a)(5). Section 4151.052(a)(5) provides that the application for an administrator certificate of authority "must include the following: . . . any other information the commissioner reasonably requires." Therefore, §7.1604(e) is a statutory authorization that must be applied within the context of the authorizing statute. As such, §7.1604(e) is not overly broad and does not give the Commissioner "unlimited authority to request any information deemed appropriate whether the information is or is not related to issues, facts, or circumstances germane to whether or not an application for a certificate of authority should be approved." Also, because §7.1604(e) is a statutory authorization that must be applied within the context of the authorizing statute, it is in accordance with §4151.006 of the Insurance Code, which authorizes the Commissioner to adopt rules that are fair, reasonable and appropriate to augment and implement the Insurance Code Chapter 4151.

§7.1607(b). Facts and Circumstances Affecting Issuance of Certificate of Authority: Notification of Material Change in Fact or Circumstance

Comment: One commenter contends that the requirement in proposed §7.1607(b) to notify the Department not later than the 30th day from the date an administrator or applicant becomes aware of any administrative action, order or judgment against the applicant or administrator is burdensome, unnecessary, and would require additional filings with the Department at odd time intervals. The commenter requests that proposed §7.1607(b) be modified to require that the administrator provide information to the Department pertaining to administrative actions, orders or judgments at the time of application or upon the annual renewal of the administrator's certificate of authority.

Agency Response: The Department disagrees and declines to make the change. First, the Department believes that the reporting of this information in a timely manner is necessary in order for the Department to monitor material changes in facts and circumstances that may affect the administrator's continued compliance with the requirements of the Insurance Code Chapter 4151 and these rules. This monitoring is necessary to implement the Insurance Code §4151.052. Proposed §7.1607(a) and (b), which are adopted without change, are consistent with the Insurance Code §4151.052(a)(5), which provides that an application for a certificate of authority to engage in business as an administrator must include "any other information the commissioner reasonably requires." Section 7.1607(b) is consistent with the Insurance Code §4151.052(b), which provides that "An applicant for a certificate of authority or a certificate holder under" Chapter 4151 "shall notify the department of any other fact or circumstance affecting the applicant's or certificate holder's qualifications for a certificate of authority in this state as required by commissioner rule." Section 7.1607(a) defines the phrase "material change in fact or circumstance" as any fact or circumstance that impacts the accuracy or completeness of the information filed in an applicant's or administrator's initial application for a certificate of authority under the Insurance Code Chapter 4151 and provides a non-exclusive list of material changes in fact or circumstances. These material changes in fact or circumstances include "any administrative action, order, or judgment issued against an applicant or administrator." Section 7.1607(b) requires an administrator to notify the Department in writing of a material change in fact or circumstances not later than the 30th day from the date the administrator first becomes aware of the material change in fact or circumstance. The Department believes that the 30-day notification requirement in §7.1607(b) is reasonable, appropriate, and necessary because this kind of information, which includes any administrative action, order, or judgment issued against an applicant or administrator, may reflect negatively on the competence, fitness, or trustworthiness of the administrator or on the financial health of the administrator. If a reported change in fact or circumstance adversely reflects upon the integrity or financial health of the administrator, the Department must be able to take any necessary action as quickly as possible to prevent any injury to the public and insurance consumers of this state. Certainly, any administrative action, order, or judgment issued against an applicant or administrator is within the ambit of information that could adversely reflect upon the integrity or financial health of the administrator and which could require quick action by the Department to prevent any injury to the public and insurance consumers of this state. Second, the Department is of the opinion that the commenter's suggested change that would require the administrator to provide information to the Department pertaining to administrative actions, orders or judgments upon the annual renewal of the administrator's certificate of authority is inconsistent with the Department's statutory obligation in the Insurance Code §4151.052(b) to monitor material changes in facts and circumstances that may affect the administrator's continued compliance with the requirements of the Insurance Code Chapter 4151 and these rules. Significantly, certificates of authority issued to administrators are not subject to annual renewal. However, even if the rule were changed to permit the annual filing of administrative actions, orders or judgments, such filing intervals could gravely reduce the effectiveness of the Department's monitoring which depends on prompt notice to the Department to enable the Department to take any immediate steps necessary to prevent any injury to the public and insurance consumers of this state. Third, §7.1607(a) and (b) replace existing §7.1612(a) and (c). Under existing §7.1612(c), an administrator is required to notify and deliver a copy of any order or judgment relating to certain specified actions to the Commissioner within 30 days of

the occurrence. Based on the Department's experience in implementing existing §7.1612(c), the Department is not aware of any instances of the requirement being overly burdensome to those required to comply.

§7.1608. Fidelity Bonds

Comment: Two commenters object to proposed §7.1608, and one commenter requests clarification concerning the requirement for fidelity bonds. One commenter contends that requiring all entities that act as administrators to obtain fidelity bonds will be burdensome and serve no identifiable interest with respect to entities who do not handle funds on behalf of an administrator. This commenter recommends that the Department revise proposed §7.1608 to require a fidelity bond only from administrators who handle claim funds or premiums. The second commenter states that the requirement in proposed §7.1608(c) for an administrator or applicant to notify the Department not later than 10 days from the date the applicant or administrator first becomes aware of the fidelity bond cancellation or termination is too short. This commenter requests that the proposed 10-day notification be extended to 30 days. A third commenter requests confirmation that the required fidelity bonds are only required of administrators and not from other persons.

Agency Response: The Department declines to make the suggested changes. Proposed §7.1608, which is adopted without change, requires each administrator and each applicant for an administrator certificate of authority to obtain and maintain a fidelity bond that complies with the requirements of the Insurance Code §4151.055 and §7.1608. The fidelity bond requirements in §7.1608 are consistent with the Insurance Code §4151.055(a), which requires an applicant to obtain and maintain a fidelity bond and submit proof to the Commissioner that the applicant obtained the required fidelity bond as a precondition to the issuance of a certificate of authority to act as an administrator under the Insurance Code Chapter 4151. Section 4141.055(b) of the Insurance Code requires that the fidelity bond protect against an act of fraud or dishonesty by the applicant or administrator in exercising the applicant's powers and duties as an administrator. Thus, to limit the applicability of §7.1608 to only administrators that handle claims funds or premiums is inconsistent with the fidelity bond requirements in the Insurance Code §4151.055. Additionally, such inconsistency between the statute and the rules creates unnecessary ambiguity which, in turn, could result in inconsistent compliance. Such inconsistent compliance could adversely effect the public and insurance consumers in Texas.

Concerning the request to reduce the notification requirement under §7.1608(c), the Department believes that 10 business days is an appropriate and reasonable amount of time under the limited circumstances in which a notification is required under §7.1608(c). Additionally, the 10-day notification requirement is necessary to implement the requirements in the Insurance Code §4151.055(a)(1) that an applicant or administrator obtain and maintain fidelity bond coverage that complies with §4151.055. An applicant or administrator is not required to comply with the 10-day notification requirement in §7.1608(c) when there is notice of cancellation or termination and the coverage is immediately replaced with sufficient new coverage. An applicant or administrator is only required to comply with the notification requirement in §7.1608(c) in circumstances in which there is cancellation or termination of the fidelity bond and coverage is not replaced with sufficient new coverage effective concurrently with the date of the cancellation or termination. Under these circumstances, an applicant or administrator is required under §7.1608(c) to immediately inform the Commissioner in writing that its fidelity bond was canceled or terminated and not replaced with new coverage effective concurrently upon the date of the cancellation or termination. The notification cannot be later than 10 business days from the date the applicant or administrator first becomes aware of the cancellation or termination.

With regard to the commenter requesting clarification or confirmation that the required fidelity bonds are only required of administrators and not from other persons, under both Chapter 4151 and these rules, fidelity bonds are only required of those that meet the definition of "Administrator" in the Insurance Code §4151.001(1) and §7.1602(1), including administrator contractors and administrators subcontractors as defined in §7.1602(3) and (4) and each applicant for an administrator certificate of authority as required under §4151.055 of the Insurance Code.

§7.1609. Annual Report.

Comment: Two commenters object to proposed §7.1609 because it will require administrators that handle only piecemeal aspects of workers' compensation claims to file annual reports. These commenters recommend that only administrators who handle funds or pay claims on behalf of a carrier or another administrator should be required to file an annual report with the Department. These commenters provide the following reasons to support their recommendations: (i) entities that handle only piecemeal aspects of workers' compensation claims will have little if anything to report, (ii) all necessary information can be obtained by way of reporting by the single entity that has overall management responsibility for an insurer, self-insured, or self-funded program, and (iii) without this change, the rules will result in duplication of data that will be difficult to analyze.

Agency Response: The Department disagrees and declines to make the suggested changes. The Insurance Code §4151.205 requires an administrator to annually file, not later than June 30, a report with the Commissioner on a form prescribed by the Commissioner, including a financial statement. Section 4151.205 requires that the report contain any information required by the Commissioner and that it be verified by at least two officers of the administrator. Proposed §7.1609, which is adopted without change, is consistent with the §4151.205 statutory requirements. To limit the applicability of §7.1609 to only certain administrators, as suggested by the commenters, is not consistent with the annual reporting requirements in §4151.205 of the Insurance Code and therefore, would exceed the Department's rulemaking authority. Further, the Department disagrees that any administrator will have "little if anything to report." The information required to be reported by an administrator under §7.1609 pertains to the administrator's activities and operations in Texas as well as the administrator's financial condition. This information is necessary for the Department to appropriately monitor an administrator's activities and operations, financial condition, and compliance with the provisions of the Insurance Code Chapter 4151 and these rules. Such monitoring is necessary to enable the Department to take any necessary action as quickly as possible in order to prevent any injury to the public and insurance consumers of this state. The Department further disagrees that all necessary information can be obtained through the reporting by the single entity that has overall management responsibility for an insurer, self-insured, or self-funded program. Because financial information is grouped and summarized for reporting purposes, it is the Department's opinion that the results, operations, performance, and business activities of individual parties may be consolidated and embedded in such a manner as to make mean-

ingful analysis problematic. Meaningful analysis is essential to ensure that the Department is able to properly monitor an administrator's activities and operations, financial condition, and compliance with the provisions of the Insurance Code Chapter 4151 and these rules. Finally, the Department disagrees that, without the recommended change, the resulting duplication of data will be difficult to analyze. To the contrary, the data reporting required by §7.1609 will result in an enhanced level of disclosure of an administrator's activities and operations and financial condition and will thereby, augment the ability of the Department to monitor compliance with Chapter 4151 and these rules. This too will assist the Department in taking appropriate regulatory action when needed to prevent any injury to the public and insurance consumers of this state.

§7.1611. Operational Review and On-Site Audit

Comment: Five commenters object to the semi-annual operational review requirements and on-site audit requirements of administrators in proposed §7.1611. According to one commenter, the semi-annual operational review and on-site audit requirements will result in many insurers being required to conduct operational reviews of multiple administrators at great expense and time, and such a requirement and the resulting costs and the costs associated with an on-site audit of an administrator is expected to significantly increase insurers' operational costs in a manner that is not reasonable nor anticipated by the Texas Legislature when it passed HB 472. This commenter recommends that the Department revise proposed §7.1611(a) to allow the semi-annual operational reviews be conducted electronically through the review of claims data. According to a second commenter, the scope and burdens associated with the required semi-annual operational review and on-site audit requirements are staggering and out of proportion to any perceived benefit that could be gained by such audits and reviews. This commenter contends that the proposed audit requirements in themselves are unduly burdensome and unworkable, and asserts that for administrators with many customers and for insurers who frequently use administrators, the number of operational reviews and audits taking place for all these plans would be staggering. This commenter further argues that the scope of the required review and audit is overly broad. Specifically, the commenter contends that proposed §7.1611(d)(1)(A) is too broad and ambiguous because an insurance carrier is not in a position to judge whether a third party administrator is in compliance with the entirety of the Insurance Code, the Labor Code, and all applicable regulations, and a carrier has neither the resources nor the responsibility to assess all areas of an administrator's operations to determine whether the administrator is in compliance with all statutory and regulatory requirements of the Labor Code and Insurance Code. This commenter also specifically objects to the on-site audit requirements because (i) they would be extremely burdensome and costly yet would provide no real benefits over an audit via electronic means; and (ii) for administrator subcontractors, they would be a practically impossible burden to satisfy, prohibitively expensive, and time-consuming. Additionally, this commenter argues that requiring all insurers and self-insurers who use administrators to engage in numerous, successive, overly broad on-site audits and operational reviews of administrators and subcontractors creates a highly inefficient, costly administration system that may lead to more employers opting out of workers' compensation. This commenter recommends that (i) proposed §7.1611 be revised by deleting the proposed on-site audit requirements and allowing for audits via electronic means; (ii) proposed §7.1611 be modified to limit the scope of operational reviews and/or on-site audits to administrators only and not every subcontractor and to focus only on whether claims are being paid appropriately and on time; (iii) proposed §7.1611(d)(1)(A) be deleted, or alternatively, at a minimum, modified to clarify the specific regulations or statutes that a carrier is in position to assess the administrator's compliance; (iv) insurers be given discretion with respect to timing and scope of review and audit of documents and practices they deem appropriate; a more workable and practicable resolution would be that the insurers should provide for their right to audit in the written contract; and (v) in place of the overly broad mandatory audit and operational review system envisioned by proposed §7.1611, the Department be required to perform oversight of administrators as part of the Department's administrator certification and recertification process, including examinations to determine whether the administrators are paying benefits to injured workers in a timely and appropriate manner, and if not, then the Department should be required to engage in additional examinations of such entities and impose sanctions as warranted. According to a third commenter, the semi-annual operational review and on-site audit requirements in proposed §7.1611 are onerous and arbitrary. This commenter requests that the Department revise proposed §7.1611 to allow carriers discretion regarding oversight of the administrators with whom they contract, taking into account the level of risk, the cost/benefit associated with the type of services provided, and the strength of the underlying contract. A fourth commenter requests that the obligations of an insurer in proposed §7.1611 be limited to inspection of an "administrator" and not also an administrator subcontractor, and requests that the phrase "by electronic means" be added to proposed §7.1611. A fifth commenter contends that for ancillary providers (administrator subcontractors), the semi-annual operational review and on-site audit requirements in proposed §7.1611 will add little value to the regulatory process, and will be very costly.

Agency Response: The Department disagrees and declines to make the requested changes. The Department disagrees that (i) the semi-annual operational review and on-site audit requirements in proposed §7.1611 are overly broad, unduly burdensome, unworkable, out of proportion to any perceived benefit, onerous, arbitrary, or will significantly increase insurers' operational costs in a manner that is not reasonable nor anticipated by the Texas Legislature when it passed HB 472; (ii) the on-site audit requirements are extremely burdensome and costly; (iii) the on-site audit requirements would be a practically impossible burden to satisfy, prohibitively expensive, and time-consuming for administrator subcontractors; and (iv) the semi-annual operational review and on-site audit requirements for administrator subcontractors will add little value to the regulatory process and will be very costly. Proposed §7.1611, which is adopted without change, is necessary to implement the requirements of the Insurance Code §4151.1042, which was enacted as part of HB 472. Section 4151.1042(c) provides that: "If an administrator administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the administrator. At least biennially, the insurer shall conduct an on-site audit of the operations of the administrator." (emphasis added). Section 4151.1042(b) requires an insurer to ensure competent administration of its programs. Section 4151.1042(a) provides that if an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, reimbursement procedures, and claims payments procedures applicable to the coverage and

for securing reinsurance, if any, and requires the insurer to provide each of its administrators with a copy of the written requirements applicable to these matters. Section 4151.1042(a) further requires that the responsibilities of the administrator as to any of these matters be set forth in the written agreement between the administrator and the insurer. As required by the Insurance Code §4151.1042(c) and §7.1611(a) and (b), the semi-annual review and biennial on-site audit requirements in §7.1611 apply only to an insurer, as defined in the Insurance Code §4151.001(2), that uses the services of an administrator that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders. The operational review and audit of administrators by insurers required by the Insurance Code §4151.1042 and §7.1611 are significant because an insurer retains the ultimate responsibility and accountability for each function it delegates to an administrator. Thus, it is imperative that an insurer appropriately monitor the activities of each of its administrators to ensure their competent administration as contemplated by §4151.1042(b). This includes, but is not limited to, ensuring the administrator's compliance with the written agreement entered into between the insurer and the administrator and compliance with the applicable provisions of Insurance Code, the Labor Code, and rules adopted thereunder relating to their administration on behalf of the insurer. In addition to the §7.1611(a) and (b) requirements, §7.1611(d) and (e) prescribe the minimum information that an insurer must review during the required review or on-site audit in order to ensure that each administrator is competently performing its administrative functions and services on behalf of the insurer in compliance with the provisions of the written agreement with the insurer and with applicable provisions of the Insurance Code, Labor Code, and rules adopted thereunder. Specifically, §7.1611(d)(1) requires that at a minimum, the operational review or on-site audit include evaluating (i) an administrator's compliance with applicable provisions of the Insurance Code, Labor Code, and rules adopted thereunder; (ii) compliance with the written agreement between the administrator and the insurer; (iii) the administrator's performance of claims adjudication and payment functions; (iv) the adequacy of the financial security maintained by the administrator, if any, such as the adequacy of security maintained for reimbursement of the amount paid by an insurance company that is payable from the deductible amounts of negotiated deductible workers' compensation policies under the Insurance Code §2053.203 and §8.4 of Title 28 of the Texas Administrative Code; and (v) the administrator's practices and procedures for establishing the adequacy of the insurer's reserves, if any. Section 7.1611(d)(2) also requires an insurer to develop a written summary of the objectives and scope of and a summary of the results of the review and on-site audit. Each summary must include a corrective action plan addressing any deficiencies found during the review or on-site audit. Section 7.1611(e) specifies that the purpose of the on-site audit is to verify the accuracy, integrity, and completeness of the information received during a review conducted by an insurer pursuant to §7.1611(a). Section 7.1611(e) also requires that an on-site audit include: (i) a physical inspection of the administrator's place of business; and (ii) a written assessment of the reliability of the information provided to the insurer and relied upon by the insurer when conducting a review or on-site audit of the administrator. Review of the prescribed information through both reviews and on-site audits should enable an insurer to better assess its ability to meet its obligations under the Insurance Code, Labor Code, and rules adopted thereunder. Additionally, it is anticipated that an insurer's regular review of the required information will enable the insurer to foresee potential financial problems or solvency issues at a much earlier date, so that corrective action can be taken immediately.

Many, if not most, of the costs objected to by the commenters are the result of the Insurance Code §4151.1042 operational review and audit requirements, and not a result of these rules. These rules, however, include provisions that will reduce insurer's costs to implement the §4151.1042 requirements. For example, notwithstanding the §7.1611(a) and (b) operational review and audit requirements, §7.1611(c) permits an insurer to forego one review of an administrator in the same fiscal year in which the insurer audits the same administrator. As a result, §7.1611(c) will assist in reducing an insurer's review costs. Also, consistent with insurer responsibility and administrator oversight requirements in the Insurance Code §4151.1042, the requirements of §7.1611 impose a minimal level of oversight and responsibility on each insurer that utilizes the services of an administrator. This applies regardless of an administrator's contractual position, whether as a direct contractor or a downstream subcontractor. Further, §7.1611 does not dictate the precise methods, practices, systems, or procedures that must be utilized by an insurer during its review or audit of an administrator. Therefore, each insurer has the flexibility to use the most economical means of compliance with the §7.1611 requirements. For example, some insurers may already have certain review or auditing procedures in place that meet all or the majority of the §7.1611 requirements. In addition, §7.1611 provides options for compliance with the various requirements. Therefore, insurers are able to select options that will result in less costs being expended, such as performing the semi-annual operational reviews through electronic means. Also, for example, §7.1611(a) permits an insurer to conduct a review of an administrator on its own premises or at another designated location. This allows an insurer to choose the most economical location for performing its review. Also, §7.1611(f) permits a review or on-site audit to be performed by an insurer or the insurer's designated representative. Because the proposed new requirements do not require an on-site audit to be conducted by an actuary or an independent CPA, an insurer may use its own employees to conduct an on-site audit. This also may result in costs savings. Finally, the probable costs of compliance with §7.1611 will vary substantially among insurers depending upon the following factors: (i) the number of administrators the insurer is required to review and audit; (ii) the size and complexity of the organization of each administrator the insurer is required to review and audit; (iii) the number of hours an insurer needs to review a particular administrator's information; (iv) the adequacy of each administrator's books and records; (v) whether an administrator's internal controls are adequate; (vi) whether the insurer is already reviewing and auditing a particular administrator; (vii) whether the insurer is able to review the administrator through electronic means; and (viii) whether an insurer discovers substantial problems during a review or audit, including the depth and complexity of those problems. Significantly, the §7.1611 review and auditing requirements are consistent with prudent business practices. Therefore, the Department does not anticipate that most insurers utilizing the services of an administrator will need to make significant changes to their current review and auditing methods, systems, practices, and procedures. Additionally, consistent with the Insurance Code §4151.1042(c), the operational review and audit requirements in §7.1611 would not apply to each and every subcontractor, but only to a subcontractor that is also an administrator, as defined in §7.1602(4), and only to an administrator subcontractor that

administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of the insurer.

The Department disagrees with the objections to the requirements related to the semi-annual operational review and on-site audit requirements for administrator subcontractors for the following reasons. Section 7.1602(4) defines an "Administrator subcontractor" as: "An administrator as defined in the Insurance Code §4151.001(1) who contracts or enters into an agreement with an administrator contractor for the performance of all or a portion of the administrative services the administrator contractor previously agreed to perform on behalf of an insurer, HMO, plan sponsor, or group. The term does not include a person described by the Insurance Code §4151.002 or §4151.0021." An insurer remains responsible for monitoring and overseeing the activities of all of its administrators, including its administrator contractors and administrator subcontractors. However, it may be appropriate for the administrator contractor that delegates the performance of a specific function to an administrator subcontractor to oversee the performance of that administrator subcontractor on the insurer's behalf. Therefore, §7.1611(g) provides an insurer with the option of meeting the §7.1611 monitoring and oversight requirements for an administrator subcontractor by reviewing and auditing its administrator contractor only. However, an insurer may utilize this option only if two requirements are met. First, an administrator contractor must supply the insurer with all the necessary and relevant information relating to a particular administrator subcontractor. Second, the information provided to the insurer by the administrator contractor must indicate that no evidence of material non-compliance by the administrator subcontractor exists. If these two requirements are met, an insurer may utilize the option provided by §7.1611(g). This provision will result in fewer reviews and audits and will assist in reducing costs. Furthermore, none of the review or on-site audit requirements in §7.1611 impose any additional burdens, conditions, or restrictions on a person, including an administrator or insurer, beyond or inconsistent with the Insurance Code Chapter 4151.

The Department also disagrees that §7.1611(d)(1)(A) is overly broad or ambiguous because it requires an insurer to conduct reviews and on-site audits to determine whether a third party administrator is in compliance with the entirety of the Insurance Code, the Labor Code, and all applicable regulations. Section 7.1611(d)(1)(A) is necessary to implement §4151.1042(a) and (b) of the Insurance Code. As previously explained, §4151.1042(a) requires an insurer to ensure competent administration of its programs, and §4151.1042(b) provides that if an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, reimbursement procedures, and claims payments procedures applicable to the coverage. Section 7.1611(d)(1)(A) requires the insurer to conduct both a review and an on-site audit as required under §4151.1042 and §7.1611(a) and (b) to assess the business practices and procedures of the administrator to ensure competent administration, including evaluating the administrator's compliance with the Insurance Code, the Labor Code, and any rules adopted thereunder, as applicable. Therefore, <*>7.1611(d)(1)(A) does not require Insurance Code an insurer to conduct reviews and on-site audits to determine whether a third party administrator is in compliance with the entirety of the Texas Insurance Code, the Texas Labor Code, and all applicable regulations. Rather, an insurer is required to conduct reviews and on-site audits to determine whether a third party administrator is in compliance with only those provisions of the Insurance Code, Labor Code, and regulations promulgated thereunder that are applicable to the administrative service being performed or offered to be performed by the administrator on behalf of the insurer.

Because of the statutory requirements in §4151.1042, the Department would exceed its rulemaking authority to adopt the commenter's recommendations to: (i) allow the semi-annual operational reviews to be conducted electronically through the review of claims data only; (ii) delete the proposed on-site audit requirements; (iii) limit the scope of operational reviews and/or audits to administrators only and not subcontractors and focus only on whether claims are being paid appropriately and on time; (iv) grant insurers with discretion with respect to timing and scope of review and audit of documents and practices they deem appropriate and provide that the insurers provide for their right to audit in the written contract; (v) allow insurers' discretion regarding oversight of the administrators with whom they contract, allowing them to take into account the level of risk, the cost/benefit associated with the type of services provided, and the strength of the underlying contract; and (vi) require the Department to examine administrators, as part of its oversight of administrators' certification and recertification process, to determine whether the administrators are paying benefits to injured workers in a timely and appropriate manner, and if the Department determines that they are not, require the Department to conduct additional examinations of such entities and impose sanctions as warranted.

Comment: One commenter objects to the requirement in proposed §7.1611(d)(2) that insurers include a corrective action plan in the report of the operational review and on-site audit of the administrator due to an emerging trend of bad faith lawsuits being filed against workers' compensation insurers. This commenter requests that the Department delete proposed §7.1611(d)(2), which requires a corrective action plan when deficiencies are identified during a review or audit. The commenter further states that it does not object to insurers being required to develop a corrective action plan that could be requested by the Department should a need arise wherein Department staff would need to obtain a copy of an insurer's corrective action plan.

Agency Response: The Department declines to make the requested deletion of §7.1611(d)(2). Proposed §7.1611(d)(2), which is adopted without change, requires an insurer to develop a written summary of the objectives and scope of the review or on-site audit and a summary of the results of the review or on-site audit, which must include a corrective action plan addressing any deficiencies found during the review or on-site audit. The Department's response is based on the following reasons. First, the §7.1611(d)(2) requirement is necessary to implement the fundamental purpose of the Insurance Code §4151.1042, which is to require insurers to exercise appropriate oversight over administrators to whom they have delegated the authority to perform statutorily required duties on behalf of the insurers in Texas. Second, §4151.1042(b) and (c) specifically require an insurer to ensure competent administration of its programs and to conduct periodic reviews and on-site audits of its administrators that, in the aggregate, administer benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders. Section 7.1611(d)(2) implements §4151.1042(b) and (c). For example, administrators are often delegated the responsibility to timely pay medical benefits and workers' compensation ben-

efits on behalf of insurers, HMOs, plan sponsors, and groups. Many administrators have control over insurers' books and records and claims files. Because an insurer retains ultimate responsibility and accountability for the functions performed by its administrators, it is imperative that each insurer monitor the activities of its administrators, maintain appropriate oversight over its administrators, and take appropriate corrective action promptly to correct any deficiencies found by the insurer during a review or on-site audit or by other means. Therefore, §7.1611, including §7.1611(d)(2), is necessary to establish appropriate minimum insurer oversight requirements for its administrators. Appropriate minimum oversight includes requiring corrective action when deficiencies are uncovered during the course of a review or audit conducted under §7.1611 and §4151.1042(c). Third, the corrective action requirement in §7.1611(d)(2) is necessary to: (i) enable an insurer to better assess its ability to meet its obligations under the Insurance Code, Labor Code, and rules adopted thereunder; (ii) protect the interests of insurance consumers by ensuring that claims are handled appropriately and paid timely and that premium is collected, maintained and dispersed properly, regardless of whether an insurer engages the services of an administrator or performs the required functions itself; and (iii) ensure an administrator's compliance with applicable statutes, rules, and contract provisions for the functions the administrator performs on behalf of the insurer. Fourth, it is anticipated that an insurer's regular review of the required information will enable the insurer to foresee potential financial problems or solvency issues at a much earlier date, so that appropriate corrective action can be taken immediately to prevent potential harm to Texas insurance consumers. Fifth, the Department anticipates that each insurer will establish performance goals for its administrators and review the performance of its administrators to determine if those goals are being met. The Department believes that this should result in financially healthier insurers, as well as more productive and efficient administrators that are in compliance with all applicable laws and rules. Sixth, the Department believes that deleting the corrective action requirement from §7.1611(d)(2) may result in situations in which necessary corrective action to rectify deficiencies is not fully or appropriately implemented by the administrator or compelled by the insurer. Such a result runs counter to the purpose of §4151.1042 that insurers must ensure competent administration of their programs, and may result in continuing or future noncompliance by administrators. This, in turn, could ultimately result in harm to Texas insurance consumers.

The commenter's stated preference that insurers be required to develop a corrective action plan that could be requested by the Department should a need arise is addressed in §7.1611(h), as proposed and adopted without changes. Section 7.1611(h) provides that a copy of the report, including any correction action plan required under §7.1611(d)(2), be made available to the Department upon request. There is no requirement in the rules that the report, including any corrective action plan, must be automatically filed with the Department.

Comment: One commenter contends that §7.1611(a) and (b) establish an extremely low threshold of only 100 Texas-administered claims, certificate holders, policyholders or plan participants for triggering the type and frequency of operational reviews and on-site audits required by proposed §7.1611. This commenter argues that triggering such massive requirements based solely on an aggregate of 100 Texas claims, certificate holders, policyholders or plan participants seems unnecessary. This commenter suggests that the threshold be increased significantly and that it would appear to be more prudent that such review and on-site audit requirements, if they were to apply at all, apply only to those administrators with the most extensive operations in Texas.

Agency Response: The Department disagrees; additionally, the Department cannot make the requested change because to do so, would exceed the Department's rulemaking authority. The "more than 100 certificate holders, injured employees, plan participants, or policyholders" requirement is mandated in §4151.1042 of the Insurance Code. Therefore, to revise the rules in accordance with the commenter's recommendation to raise the threshold for required reviews and on-site audits would exceed the Department's rulemaking authority. Section 7.1611(a) and (b) reflect the thresholds contemplated in the Insurance Code §4151.1042(c) for determining when an insurer is required to conduct a review and an on-site audit of its administrators. The Insurance Code §4151.1042(c) provides that "If an administrator administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the administrator. At least biennially, the insurer shall conduct an on-site audit of the operations of the administrator." Section 7.1611(a) provides that "No less than two times each fiscal year, an insurer shall review the operations of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders." Section 7.1611(b) provides that "No less than once every two fiscal years, an insurer shall conduct an on-site audit of each of its administrators that, in the aggregate, administers benefits in Texas on behalf of the insurer for more than 100 certificate holders, injured employees, plan participants, or policyholders."

Comment: One commenter states that the semi-annual operational review requirements in proposed §7.1611(a) do not make sense since proposed §7.1607(a) and (c) require administrators to report any material change in fact or circumstances that impacts the accuracy or completeness of the information filed in an applicant's or administrator's initial application. The commenter suggests that the Department amend §7.1607(a) and (c) to require that an administrator provide the insurer with a copy of their notification to the Department of any material changes that must be reported pursuant to §7.1607.

Agency Response: The Department disagrees and declines to make the recommended revisions for the following reasons. First, §7.1607(a) and (c) and §7.1611(a) implement completely different requirements in the Insurance Code Chapter 4151. The operational review requirements in proposed §7.1611(a), which are adopted without change, are necessary to implement the Insurance Code §4151.1042. Section 4151.1042 mandates the monitoring and oversight requirements of insurers over their administrators. Proposed §7.1607(a) and (c), which are also adopted without change, are necessary to implement the Insurance Code §4151.052(b). Section 4151.052(b) mandates certain reporting of administrators to the Department in accordance with rules adopted by the Commissioner. Except as provided by §7.1606(b), §7.1607(c) requires an applicant to continually update the information filed in its initial application for a certificate of authority. This includes notifying the Department in writing of a material change in fact or circumstance, while the application is pending with the Department, as required under §4151.052(b). This required notification is necessary to enable the Department to accurately assess an applicant's fitness for

licensure. Further, if a reported change in the information filed in an applicant's initial application for a certificate of authority prevents an applicant from fulfilling the minimum requirements necessary for the Department to approve its application, the Department must be able to identify and assess those situations quickly and accurately. Second, the information an administrator is required to report to the Department under §7.1607(a) and (c) may involve confidential, proprietary, or commercially sensitive information from the perspective of the administrator. Third, to revise §7.1607(a) and (c) to require that an administrator provide the insurer with a copy of their notification to the Department of any material changes reported pursuant to §7.1607 would impose additional requirements on administrators that are not included in the proposed rules. Pursuant to Texas case law, this would be a substantive change to the proposed rules and would require re-publication of the proposal with an additional 30-day comment period.

§7.1613(d)(1). Written Agreements Between Administrators and Insurers

Comment: One commenter objects to proposed §7.1613(d)(1) because it contends that citing compliance with specific Texas state laws would be onerous and impracticable in agreements that address services provided in numerous jurisdictions on a national basis. The commenter recommends that the requirement that the written agreements contain references to several specific Texas statutes be deleted, or if not deleted, then the deadline for implementation of the written agreement provisions should be extended until at least June 1, 2010. According to the commenter, agreements between insurers and administrators often contain general provisions that the administrator shall comply with all applicable laws and regulations.

Agency Response: The Department agrees with the commenter's concern, but disagrees with the commenter's recommended changes to proposed §7.1613. Therefore, the Department has revised §7.1613(d)(1) as adopted to state that a written agreement entered into under §7.1613 "shall include a requirement that the administrator must comply with all statutory, contractual, and regulatory requirements related to a function assumed or carried out by the administrator and related to a plan for which the administrator performs or offers to perform administrative services." The Department believes that §7.1613(d)(1), as revised, will give insurers and administrators more flexibility in meeting the §7.1613(d)(1) requirement. The Department expects each administrator to comply with all applicable requirements of the Insurance Code and the Labor Code and rules adopted thereunder, including holding the appropriate licenses or certificates of authority under the Insurance Code or the Labor Code. The language in §7.1613(d)(1), as revised, implements the Insurance Code §§4151.101 - 4151.103, 4151.253, 4151.257, concerning written agreements between administrators and insurers or plan sponsors.

§7.1614. Prohibited Acts

Comment: One commenter objects to proposed §7.1614 because it is not clear what inducements are considered improper under proposed §7.1614. The commenter describes certain payments to companies that receive as part of their compensation a percentage of the difference between the DWC's fee schedule amount and the ultimate amount paid to the health care provider (referred to as "PPO reductions"). The commenter states that these companies audit and make recommendations for payment or reduction of medical bills relating to workers' compensation claims. The commenter then states that this compensation might be considered an "improper inducement" under proposed §7.1614(a)(5), but that it is not clear from the wording. The commenter states that if the Department considers such payments or any other payments to be improper inducements, then it would be more clear to system participants if proposed §7.1614 was to reference Insurance Code §4151.117 as well as Labor Code §415.0036. The commenter states that perhaps that is what is intended by proposed §7.1614(b), but it is not clear.

Agency Response: The Department disagrees that proposed §7.1614, which is adopted without change, is unclear and declines to make the recommended change because it is not necessary. Section 7.1614(b) addresses the commenter's concern. Section 7.1614(b) provides that an administrator may be subject to other prohibitions under the Insurance Code, the Labor Code, and rules adopted thereunder that are not specified in §7.1614(a). Section 7.1614(b) includes the prohibition in the Insurance Code §4151.117(b). Section 4151.117(b) prohibits an insurer or plan sponsor from permitting or providing compensation or another thing of value to an administrator that is based on the savings accruing to the insurer or plan sponsor because of adverse determinations regarding claims for benefits, reductions of or limitations on benefits, or other analogous actions inconsistent with Chapter 4151, that are made or taken by the administrator.

§7.1615. Transfer of Books and Records

Comment: One commenter objects to the notification requirements in proposed §7.1615(d) and (e) because they would create an enormous administrative burden for administrators and the Department with no real benefit. The commenter also disagrees with the Department's estimated $60 cost of compliance with the 30-day notice requirements in proposed §7.1615(d) and (e) and argues that an administrator will not be able to pass this cost on to an insurer or to another administrator, as mentioned on pages 59 through 94 of the Department's proposal published in the *Texas Register* on December 5, 2008. This commenter requests the notification requirements in proposed §7.1615(d) and (e) be deleted. The commenter states that there are literally thousands of such contractual relationships which change on a frequent basis, and that if the proposed rule is left unchanged, the Department may be inundated with hundreds of such notices assuming that administrators are able to track all the contractual changes that take place.

Agency Response: The Department declines to make the requested deletion of the notification changes. The Department disagrees that the notification requirements in proposed §7.1615(d) and (e), which are adopted without changes, will be an administrative burden on an administrator or the Department. The Department also disagrees that §7.1615(d) and (e) provide no real benefit. Section 7.1615(d) and (e) are necessary to implement the Insurance Code §4151.103(d), which requires the Commissioner to adopt rules to address the transfer of records from one administrator to another. Section 7.1615(d) and (e) also are consistent with the statutory provisions in the Insurance Code §4151.112 (Maintenance of Books and Records), §4151.113 (Access to Books and Records), and §4151.114 (Disposition of Books and Records or Termination of Agreement). Section 7.1615(d) and (e) do not, as the commenter contends, require administrators to notify the Department of every change to a written agreement between administrators or between administrators and insurers, HMOs, plan sponsors, or groups. Rather, §7.1615(d) and (e) require a written notice to the

Department only in situations in which a relationship or written agreement is terminated. The Department anticipates that this requirement will mitigate the problems that the Department has experienced concerning the termination of agreements between administrators or between administrators and insurers, HMOs, plan sponsors, or groups, including instances involving the disruption of claim payments during the transition when books and records are transferred to a new carrier or administrator. The notification requirements in §7.1615(d) and (e) provide the Department with the opportunity to monitor specific transition periods to ensure that claims are timely paid, premiums are appropriately collected and transferred, and the financial condition of insurers, HMOs, plan sponsors, groups, and administrators remain stable. Finally, administrators have been required since 1989 to send a similar written notice to the Department under the Insurance Code §4151.114 (formerly Article 21.07-6 §14(g). Based on the Department's experience in implementing §4151.114 (formerly Article 21.07-6 §14(g)), the Department is not aware of any instances of the notice requirement creating an enormous administrative burden for administrators or the Department. Although this notice requirement has existed for many years, the Department in recent years has experienced some problems including instances involving the disruption of claim payments. As a result of these problems, the proposal reiterates the §4151.114 statutory requirement in §7.1615(d) and (e). The Department believes that this may reduce future non-compliance with §4151.114 and thereby, reduce future disruptions in claim payments.

The Department also disagrees that the Department's cost estimate was understated. Because the commenter inaccurately read proposed §7.1615 to require notice to the Department of the "literally thousands of such contractual relationships which change on a frequent basis," it is understandable that the commenter would think that the cost note for the notice requirement was understated. As previously explained, §7.1615(d) and (e) do not require administrators to notify the Department of every change to a written agreement between administrators or between administrators and insurers, HMOs, plan sponsors, or groups. Rather, §7.1615(d) and (e) require a written notice to the Department only in situations in which a relationship or written agreement is terminated. Therefore, the Department believes that it provided an accurate estimation of the probable associated costs of compliance with the §7.1615 notification requirements. In the Public Benefits/Cost Note section of the Department's proposal, the Department stated that it anticipates that the total probable costs for complying with the §7.1615 notification requirements will be less than $60. This estimation is based upon (i) a member of an administrator's administrative staff preparing the necessary information in less than one hour, at an estimated mean salary rate of $14.13 per hour; and (ii) a member of an administrator's management staff reviewing and approving the prepared information in less than one hour, at an estimated mean salary rate of $44.87 per hour. The Department expects the notice typically to take the form of a simple letter that, depending on the circumstances, may require only a few sentences to comply with the §7.1615(d) and (e) requirements. Additionally, based upon the experience of the Department, the Department believes that administrators generally charge their clients amounts that are typically designed to be sufficient to cover the administrative expenses incurred by those administrators. Section 7.1615(c) provides each administrator with the flexibility to negotiate the most economical means of complying with the §7.1615 requirements.

§7.1616. Hazardous or Injurious Operating Conditions

Comment: Three commenters object to proposed §7.1616 as overly broad, overreaching, open-ended, or unclear. The reasons provided to support their objections are that proposed §7.1616: (i) is not specific enough about what may constitute "any unlawful activity" by management staff as referenced in proposed §7.1616(a)(6); (ii) is not specific enough about what may constitute "hazardous or injurious manner" as referenced in proposed §7.1616(b); (iii) includes circumstances under which an applicant or administrator may be considered by the Department to be operating or conducting business in a hazardous or injurious manner that exceed the list of grounds for which the Department may deny, suspend or revoke a certificate of authority under the Insurance Code §4151.301; (iv) does not specify the basis for determining that an applicant or administrator is operating in a hazardous or injurious manner; the commenter cites the Texas Constitution, Article I, Sections 13 and 19 and case law for support; and (v) leaves a large loophole to allow the Department to identify virtually any practice as "hazardous." One commenter states that while it appreciates that the Department cannot define in regulation each and every possible hazardous or injurious condition, it recommends revising proposed §7.1616(b) to state "other activities similar in nature and effect to the activities identified in subsection (a)." This commenter states that this revision will provide clearer guidance to the industry. A second commenter suggests that proposed §7.1616 be revised to be more specific, perhaps by cross-referencing the laundry list of improper acts contained in the Insurance Code §4151.301. A third commenter recommends that the Department revise proposed §7.1616 to reflect that an applicant or administrator may be considered by the Department to be operating or conducting business in a hazardous or injurious manner if the Department determines that grounds exist for denial, suspension, or revocation of a certificate of authority identified in the Insurance Code §4151.301. This commenter recommends the deletion of proposed §7.1616(b). The commenter contends that the Texas Constitution, Article I, Sections 13 and 19 guarantees due process; the commenter cites to various court decisions for support. The commenter states that individuals must be afforded both substantive and procedural due process. *(Texas Workers' Comp. Comm'n v. Patient Advocates,* 136 S.W.3d 643, 658 (Tex. 2004)). Substantive due process protects against the arbitrary and oppressive exercise of government power, regardless of the fairness of the procedures. *Daniels v. Williams,* 474 U.S. 327, 331, 88 L. Ed. 2d 662, 106 S. Ct. 662 (1986). A statute which forbids or requires the doing of an act in terms so vague that men and women of common intelligence must necessarily guess at its meaning and differ as to its application violates the first essential protection of due process of law. Baker v. State, 50 S.W.3d 143, 145 (Tex. App.--Eastland 2001, pet. ref'd) *citing Connally v. General Const. Co.,* 269 U.S. 385, 46 S. Ct. 126, 70 L. Ed. 322 (1926). A statute is void for vagueness if it "fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute." *Baker v. State,* 50 S.W.3d at 145; *citing Papachristou v. City of Jacksonville,* 405 U.S. 156, 92 S. Ct. 839, 31 L. Ed. 2d 110 (1972).

Agency Response: The Department declines to make the recommended changes for the following reasons. The Department disagrees that proposed §7.1616(b) should be revised to state "other activities similar in nature and effect to the activities identified in subsection (a)." Section 7.1616(a) specifies eight illustrative examples of conduct that may indicate that an applicant or

administrator is operating or conducting business in a potentially hazardous or injurious manner. However, §7.1616(a) does not provide an exhaustive list of all possible factors or conditions relating to the financial condition or business operations or conduct of an applicant or administrator that may indicate that an applicant or administrator is operating or conducting business in a potentially hazardous or injurious condition. This is because the Department cannot define in a regulation each and every possible hazardous or injurious condition. Accordingly, the Department does not believe that it would be appropriate or sufficient from a regulatory or public policy perspective to limit §7.1616(b) to only those activities that are similar in nature and effect to the few illustrative examples reflected in §7.1616(a).

The Department also disagrees that proposed §7.1616 should be revised to reflect that an applicant or administrator may be considered by the Department to be operating or conducting business in a hazardous or injurious manner if the Department determines that grounds exist for the denial, suspension, or revocation of a certificate of authority identified in the Insurance Code §4151.301 and that §7.1616(b) should be deleted. A fundamental objective of §7.1616 is to provide regulatory guidance to the industry on one particular provision of §4151.301 of the Insurance Code, specifically §4151.301(8). Section 4151.301 specifies that the Department may deny an application for a certificate of authority or discipline the holder of a certificate of authority under Subchapter G of Chapter 4151 of the Insurance Code if the Department determines that the applicant or holder, individually, or through an officer, director, or shareholder meets one of 14 statutorily specified criteria. Section 4151.301(8), which is one of the 14 statutorily specified criteria, relates to administrators whose financial condition, operations or conduct, may render further transactions in this state hazardous or injurious to insured persons or the public. By providing applicants and administrators with guidance through illustrative examples of situations that may reflect potentially hazardous or injurious operating conditions, the Department anticipates that applicants and administrators will take preventative steps to avoid these types of situations. This should result in financially healthier applicants and administrators. Thus, the Department declines to make the suggested change, in part, because the change would negate the public policy benefits of providing regulatory guidance regarding compliance with the Insurance Code §4151.301(8). However, as a result of the comments, the Department has revised §7.1616(b) as adopted for purposes of clarity. The Department believes that this clarification addresses the commenters' concerns, including the assertion that the proposed §7.1616(b) has a loophole to allow the Department to identify virtually any practice as "hazardous". Section 7.1616(b) as adopted provides that "Other facts and circumstances not specified in §7.1616(a), as determined by the commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state may also indicate that an applicant or administrator is operating in a hazardous or injurious manner." This clarification does not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

Additionally, the Department is of the opinion that the provisions of §7.1616, as adopted, including §7.1616(b), are not overly broad, overreaching, open-ended, vague, confusing, or unclear. Section 7.1616 is authorized by the Insurance Code §4151.006 and §4151.301(8). Section 4151.006 authorizes the Commissioner to adopt rules relating to financial standards for administrators. Section 4151.301(8) authorizes the Department to deny an applicant's application for a certificate of authority, or suspend or revoke an administrator's certificate of authority, if the Department determines that an administrator or applicant is in a financial condition, or is operating or conducting business in a manner, that would render further transaction of business in this state hazardous or injurious to insured persons or the public. Section 7.1616(a) specifies in a clear manner illustrative examples of conditions that may indicate when an administrator or applicant is operating or conducting business in a way that would render further transaction of business in this state hazardous or injurious to insured persons or the public. These examples include: (i) failure to file financial statements, documents, records, or reports required under the Insurance Code Chapter 4151 or these rules within the time periods prescribed by the Insurance Code Chapter 4151, these rules, or as requested by the Department pursuant to law; (ii) the filing of any false or misleading financial information; (iii) inability of the applicant or administrator to pay its obligations as they become due and payable; (iv) failure to maintain records sufficient to permit examiners to determine its financial condition or compliance with the Insurance Code, the Labor Code, and rules adopted thereunder; (v) failure to employ management staff with the experience, competence, or trustworthiness to conduct its operations in a safe or sound manner; (vi) the employment of management staff that has engaged in any unlawful activity; (vii) failure to comply in the past or in the present with the terms of a written agreement with an insurer, HMO, plan sponsor, or group; (viii) engaging in the past or engaging in the present in a pattern of failing to settle claims in accordance with contractual, regulatory, or statutory requirements; or (ix) engaging in the past or engaging in the present in fraudulent or dishonest practices or acts. As previously explained, §7.1616(a), however, does not provide an exhaustive list of all possible factors and circumstances that the Department or Commissioner may consider when determining whether an administrator or applicant is operating or conducting business in a manner contemplated by the Insurance Code §4151.301(8). Therefore, §7.1616(b), as adopted, clarifies that in determining whether an administrator or applicant is operating or conducting business in a potentially hazardous or injurious manner, the Commissioner may consider other factors, as determined by the Commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state to determine whether an applicant or administrator is operating in a hazardous or injurious manner. Any of the specified factors in §7.1616(a) and any of the factors determined by the Commissioner pursuant to §7.1616(b) may be a basis for the Commissioner to initiate regulatory action against an administrator or applicant under the Insurance Code. However, the existence of one or more of the factors or conditions does not necessarily mean that an administrator or applicant is operating or conducting business in a manner that would render further transaction of business in this state hazardous or injurious to insured persons or the public. In evaluating any of these factors or conditions, all circumstances concerning the administrator's or applicant's condition, activities, and operations must be evaluated in order to determine whether an administrator or applicant is operating or conducting business in a potentially hazardous or injurious manner. Section 7.1616, including §7.1616(b), is necessary to ensure that corrective actions can be taken at the earliest possible point in time to alleviate or prevent harm to the public and insurance consumers of this state as a result of an administrator's hazardous or injurious operating condition. The §7.1616 provisions are substantially similar to the Department's hazardous financial condition rules in §8.3 and

§8.4 of Title 28 of the Texas Administrative Code. Section 8.3 rules relate to hazardous conditions of insurers, and §8.4 rules relate to hazardous conditions concerning negotiated deductible workers' compensation policies. It is the Department's experience in implementing §8.3 since 1989 and §8.4 since 2005 that such rules have worked well in practice to indicate certain conditions that may possibly indicate potentially hazardous conditions, while giving the Commissioner discretion to decide whether or not regulatory action is needed and the type of regulatory action to take, based on a case-by-case, fact-specific determination relating to a specific insurer. The Department's experience in implementing §8.3 and §8.4 has been that (i) the provisions have specified the basis for determining that an applicant or administrator is operating in a hazardous or injurious manner; (ii) the provisions have been specific enough about what may constitute "hazardous or injurious manner" as referenced in proposed §7.1616(b); (iii) no individual or entity has been deprived of substantive or procedural due process as a result of the rules; (iv) no individual or entity has encountered requirements so vague that men and women of common intelligence were forced to guess at their meaning; and (v) the rules have given persons of ordinary intelligence fair notice of the type of conduct that is forbidden by the statute. The Department anticipates that §7.1616 will be similarly effective and give the Commissioner the discretion needed to determine whether or not a hazardous or injurious condition exists based upon case-by-case, fact-specific determinations relating to a specific administrator. For these reasons, the Department disagrees that §7.1616 as adopted deprives any individuals of substantive or procedural due process, as contemplated in *Texas Workers' Comp. Comm'n v. Patient Advocates,* 136 S.W.3d 643, 658 (Tex. 2004) and *Daniels v. Williams,* 474 U.S. 327, 331, 88 L. Ed. 2d 662, 106 S. Ct. 662 (1986). The Department disagrees that §7.1616 as adopted forbids or requires the doing of an act in terms so vague that men and women of common intelligence must necessarily guess at its meaning and differ as to its application as contemplated in *Baker v. State,* 50 S.W.3d 143, 145 (Tex. App.--Eastland 2001, pet. ref'd) *citing Connally v. General Const. Co.,* 269 U.S. 385, 46 S. Ct. 126, 70 L. Ed. 322 (1926). The Department disagrees that §7.1616 as adopted fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute as contemplated in *Baker v. State,* 50 S.W.3d at 145; *citing Papachristou v. City of Jacksonville,* 405 U.S. 156, 92 S. Ct. 839, 31 L. Ed. 2d 110 (1972).

The Department disagrees with the comment that §7.1616(a)(6) is unclear because it does not state what may constitute "any unlawful activity" by management staff. It means exactly what it says. "Any unlawful activity" is any activity that violates any law.

§7.1617. Examinations

Comment: One commenter recommends that the Department amend proposed §7.1617(b) to require the Department to provide at least three days' notice of an inspection in order to facilitate the orderly production of claim files for audit purposes without disrupting the claims payment function, which may result in penalties for claims that are paid late during the course of the audit.

Agency Response: The Department declines to make the change. The current language is consistent with the Insurance Code §4151.202(c). Section 4151.202(c) requires the Commissioner to give notice to the administrator of the examiner's intent to conduct an on-site examination before an examiner enters an administrator's property. The notice must be (i) in the form required by rule adopted by the Commissioner and (ii) include the date and estimated time that the examiner will enter the administrator's property. In accordance with current Department practice, the Department anticipates that an approximately two weeks' prior notice will be provided of an examination. However the Department reserves the right to conduct a more expeditious examination should circumstances warrant; in such instances, notice will be provided in accordance with the Insurance Code §4151.202(c)

NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: Office of Public Insurance Counsel.

Against: None.

For, with changes: Insurance Council of Texas.

Neither for nor against, with changes: Parker & Associates, L.L.C.; American Insurance Association; American Association of Independent Claims Professionals; Texas Mutual Insurance Company; and CompPharma.

STATUTORY AUTHORITY. The new sections are adopted under the Insurance Code, the Labor Code, and the Education Code. The Insurance Code Chapter 1272 regulates the delegation of certain functions by health maintenance organizations. The Insurance Code §1272.058 provides that a delegation agreement required by the Insurance Code §1272.052 must require the delegated entity to provide the license number of a delegated third party performing a function that requires a license as a third-party administrator under the Insurance Code Chapter 4151 or utilization review agent under Article 21.58A or another license under this code or another insurance law of this state.

The Insurance Code Chapter 1305 regulates workers' compensation health care networks. The Insurance Code §1305.008 requires a person that performs the functions of an administrator under the Insurance Code Chapter 4151 to hold a certificate of authority issued under that chapter to provide those functions under the Insurance Code Chapter 1305 for an insurance carrier.

The Insurance Code Chapter 4151 regulates administrators. The Insurance Code §4151.001 defines the terms that are used in Chapter 4151, including the terms administrator, insurer, person, plan, and plan sponsor. The Insurance Code §4151.002 and §4151.0021 provide exemptions from the requirements of the Insurance Code Chapter 4151 for certain persons meeting specified conditions. The Insurance Code §4151.004 provides that an insurer or health maintenance organization that is not exempt under §4151.002(3) or (4) is subject to all provisions of the Insurance Code Chapter 4151 other than the Insurance Code §§4151.005, 4151.051 - 4151.054, 4151.056, and 4151.206(a)(1). The Insurance Code §4151.006 provides that the Commissioner may adopt rules that are fair, reasonable, and appropriate to augment and implement the Insurance Code Chapter 4151, including rules establishing financial standards, reporting requirements, and required contract provisions. The Insurance Code §4151.051(a) provides that an individual, corporation, organization, trust, partnership, or other legal entity may not act as or hold itself out as an administrator unless the entity is covered by and is engaging in business under a certificate of authority issued under the Insurance Code Chapter 4151. The Insurance Code §4151.052(a) provides that an application for a certificate of authority to engage in business as an administrator must be in a form prescribed by the Commissioner. Additionally, the Insurance Code §4151.052(a)

specifies the items that must be included in an application for a certificate of authority, including basic organizational documents of the applicant; a description of the applicant and the applicant's services, facilities, and personnel; an audited financial statement of the applicant covering the preceding three calendar years or any lesser period that the applicant and any predecessors of the applicant have been in existence; and any other information the Commissioner reasonably requires. The Insurance Code §4151.052(b) requires an applicant for a certificate of authority or a certificate holder under the Insurance Code Chapter 4151 to notify the Department in the manner prescribed by Commissioner rule of a change of control in the applicant's or certificate holder's ownership not later than the 30th day after the effective date of the change. Additionally, the Insurance Code §4151.052(b) requires an applicant for a certificate of authority or a certificate holder under the Insurance Code Chapter 4151 to notify the Department of any other fact or circumstance affecting the applicant's or certificate holder's qualifications for a certificate of authority in this state as required by Commissioner rule. The Insurance Code §4151.053 provides that the Commissioner shall approve an application for a certificate of authority to engage in business in this state as an administrator if the Commissioner is satisfied that granting the application would not violate a federal or state law; the financial condition of the applicant or of each person who would operate or control the applicant is such that granting a certificate of authority would not be adverse to the public interest; the applicant has not attempted to obtain the certificate of authority through fraud or bad faith; the applicant has complied with the Insurance Code Chapter 4151 and rules adopted by the Commissioner under the Insurance Code Chapter 4151; and the name under which the applicant will engage in business in this state is not so similar to that of another administrator or insurer that it is likely to mislead the public. Before the Commissioner issues an applicant a certificate of authority, the Insurance Code §4151.055(a) requires an applicant to obtain and maintain a fidelity bond that complies with the Insurance Code §4151.055 and to submit to the Commissioner proof that the applicant has obtained the fidelity bond. The Insurance Code §4151.101(a) provides that an administrator may provide services only under a written agreement with an insurer or plan sponsor. The Insurance Code §4151.101(b) provides that the Commissioner by rule may prescribe provisions that must be included in the written agreement. The Insurance Code §4151.102(a) provides that the written agreement must include each requirement prescribed by the Insurance Code Chapter 4151, Subchapter C, except for a requirement that does not apply to any function the administrator performs. The Insurance Code §4151.102(a-1) provides that the written agreement must include a statement of the duties that the administrator is expected to perform on behalf of the insurer, and the lines, classes, or types of insurance that the administrator is authorized to administer. Additionally, under the Insurance Code §4151.102(a-1), the agreement must include, as applicable, provisions regarding claims handling and other standards relating to the business underwritten by the insurer. The Insurance Code §4151.103(a) requires an administrator and the insurer, plan, or plan sponsor to retain a copy of the written agreement as part of their official records during the term of the agreement and until the fifth anniversary of the date on which the agreement expires. The Insurance Code §4151.103(d) provides that the Commissioner shall adopt rules to address the transfer of records from one administrator to another. The Insurance Code §4151.1042(a) provides that if an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, reimbursement procedures, and claims payment procedures applicable to the coverage and for securing reinsurance, if any. Further, under the Insurance Code §4151.1042(a), an insurer is required to provide a copy of the written requirements relating to those matters to the administrator. Additionally, the responsibilities of the administrator as to any of those matters must be set forth in the written agreement between the administrator and the insurer. The Insurance Code §4151.1042(b) provides that an insurer shall ensure competent administration of its programs. The Insurance Code §4151.1042(c) provides that if an administrator administers benefits for more than 100 certificate holders, injured employees, plan participants, or policyholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the administrator. Additionally, under the Insurance Code §4151.1042(c), an insurer is required to conduct an on-site audit of the operations of the administrator at least biennially. The Insurance Code §4151.105(a) provides that if an insurer, plan, or plan sponsor uses the services of an administrator, a payment of a premium or contribution to the administrator by or on behalf of an insured or plan participant is considered to have been received by the insurer, plan, or plan sponsor, and a payment of a return premium, contribution, or claim to the administrator by the insurer, plan, or plan sponsor is not considered payment to the insured, plan participant, or claimant until the insured, plan participant, or claimant receives the payment. The Insurance Code §4151.105(b) provides that the Insurance Code §4151.105 does not limit a right of an insurer, plan, or plan sponsor against the administrator resulting from the administrator's failure to make a payment to an insured, plan participant, or claimant. The Insurance Code §4151.106(a) provides that an administrator who collects funds must identify and state separately in writing the amount of any premium or contribution specified by the insurer, plan, or plan sponsor for the coverage and provide the information to any person who pays to the administrator a premium or contribution. The Insurance Code §4151.106(b) provides that an administrator holds in a fiduciary capacity a premium or contribution the administrator collects on behalf of an insurer, plan, or plan sponsor and a return premium the administrator receives from an insurer, plan, or plan sponsor. The Insurance Code §4151.107(a) provides that, upon receiving a premium, contribution, or return premium, an administrator shall timely deliver the funds to the person entitled to the funds according to terms of the written agreement or promptly deposit the funds in a fiduciary bank account established and maintained by the administrator. The Insurance Code §4151.107(b) provides that if premiums or contributions deposited in a fiduciary bank account were collected on behalf of more than one insurer, plan, or plan sponsor, the administrator shall maintain records that clearly record separately the deposits to and withdrawals from the account on behalf of each insurer, plan, or plan sponsor, and, upon request of an insurer, plan, or plan sponsor, provide to the insurer, plan, or plan sponsor a copy of the records relating to deposits and withdrawals on behalf of that insurer or plan. The Insurance Code §4151.107(c) provides that the requirements of the Insurance Code §4151.107(b) are in addition to requirements of any other federal or state law and do not authorize the commingling of funds if otherwise prohibited by law. The Insurance Code §4151.108(a) provides that a withdrawal from a fiduciary bank account established under the Insurance Code §4151.107 may be made only as provided in the written agreement for the purposes of delivery to an insurer, plan, or plan sponsor entitled to payment; deposit in an account

controlled and maintained in the name of the insurer, plan, or plan sponsor; transfer to and deposit in a claims payment account for payment of a claim as provided by the Insurance Code §4151.111; payment to a group policyholder for delivery to the insurer entitled to payment; payment to the administrator of the administrator's commission, fees, or charges; delivery of a return premium to any person entitled to payment, or payment of a premium for stop-loss or excess loss insurance. The Insurance Code §4151.109 prohibits an administrator from paying a claim from a fiduciary bank account established under the Insurance Code §4151.107. The Insurance Code §4151.110 provides that if an administrator has the authority to accept or reject a risk, the written agreement must address underwriting or other standards of the insurer or plan. The Insurance Code §4151.112(a) requires an administrator to maintain, at the administrator's principal administrative office, adequate books and records of each transaction in which the administrator engages with an insurer, plan, plan sponsor, insured, or plan participant. The Insurance Code §4151.112(b) requires an administrator to maintain the books and records until the fifth anniversary of the end of the term of the written agreement to which the books and records relate and in accordance with prudent standards of insurance recordkeeping. The Insurance Code §4151.113(a) provides that, for the purpose of examination, audit, and inspection, an administrator shall provide to the Commissioner and the Commissioner's designee access to the books and records maintained as required by the Insurance Code §4151.112. The Insurance Code §4151.113(b) makes a trade secret, including the identity and address of a policyholder, certificate holder, or injured employee, confidential. The Insurance Code §4151.113(b) also permits the Commissioner to use a trade secret, including the identity and address of a policyholder, certificate holder, or injured employee in a proceeding against an administrator. The Insurance Code §4151.113(c) provides that an insurer, plan, or plan sponsor is entitled to continuing access to the books and records sufficient to permit the insurer, plan, or plan sponsor to fulfill a contractual obligation to an insured or plan participant. Further, the Insurance Code §4151.113(c) provides that the right provided by the Insurance Code §4151.113(c) is subject to any restriction included in the written agreement relating to the parties' proprietary rights to the books and records. The Insurance Code §4151.114 provides that, upon termination of the written agreement, an administrator may fulfill the requirements of the Insurance Code §4151.112 and §4151.113 by delivering the books and records to a successor administrator, or if there is not a successor administrator, to the insurer, plan, or plan sponsor, and by giving written notice to the Commissioner of the location of the books and records. The Insurance Code §4151.116 requires an insurer, plan, or plan sponsor to approve the use of any advertising relating to the business underwritten by the insurer, plan, or plan sponsor before an administrator uses such advertising. The Insurance Code §4151.201(a) provides that the Commissioner may examine an administrator with regard to its business in this state. The Insurance Code §4151.201(b) provides that the Commissioner may designate one or more employees to perform an examination. The Insurance Code §4151.201(b) provides that the Commissioner also may have examiners conduct an on-site evaluation of the administrator's personnel and facilities and any books and records of the administrator relating to the transaction of business by and the financial condition of the administrator. The Insurance Code §4151.201(c) provides that before an examiner enters an administrator's property, the Commissioner shall give notice to the administrator of the examiner's intent to conduct an on-site evaluation. Further, under the Insurance Code §4151.201(c), the notice must be in the form required by rule adopted by the Commissioner and include the date and estimated time that the examiner will enter the administrator's property. The Insurance Code §4151.201(d) provides that an examiner shall comply with operational rules of an administrator while on the administrator's property. The Insurance Code §4151.202(a) provides that an examination under the Insurance Code §4151.201 must include a review of each existing written agreement between the administrator and an insurer or plan sponsor and the administrator's financial statements. The Insurance Code §4151.203 provides that the cost of an examination under the Insurance Code §4151.201 shall be paid from the fee collected under the Insurance Code §4151.206(a)(2) and with revenue from the maintenance tax levied under the Insurance Code Chapter 259. The Insurance Code §4151.205(a) requires an administrator, not later than June 30, to annually file with the Commissioner a report on a form prescribed by the Commissioner. Further, under the Insurance Code §4151.205(a), the report must contain any information required by the Commissioner and must be verified by at least two officers of the administrator. The Insurance Code §4151.205(b) requires the annual report to cover the preceding calendar year. Except as provided by the Insurance Code §4151.205(f), the Insurance Code §4151.205(c) requires the annual report to include an audited financial statement performed by an independent certified public accountant. Further, under the Insurance Code §4151.205(c), an audited financial statement prepared on a consolidated basis must include a columnar consolidating or combining worksheet that shall be filed with the annual report. Additionally, the amounts shown on the consolidated audited financial report must be shown on the worksheet, the amounts for each entity must be stated separately, and explanations of consolidating and eliminating entries must be included. The Insurance Code §4151.205(d) requires the annual report to include notes to the financial statement or attachments that reflect the complete name and address of each insurer in this state with which the administrator had an agreement during the preceding fiscal year. The Insurance Code §4151.205(e) provides that information derived from an audited financial statement contained in an annual report under the Insurance Code §4151.205 is confidential and is not subject to disclosure under the Government Code Chapter 552. The Insurance Code §4151.205(f) provides that an administrator who receives less than $10 million annually as compensation for performing administrative services and operates under written agreements subject to the Insurance Code Chapter 4151 with insurers or plan sponsors in this state is not required to file an audited financial statement under the Insurance Code §4151.205(c), but must file a financial statement certified in the manner prescribed by Commissioner rule. The Insurance Code §4151.206(a) provides that the Commissioner shall collect and an applicant or administrator shall pay to the Commissioner, in an amount to be determined by the Commissioner, a filing fee not to exceed $1,000 for processing an original application for a certificate of authority for an administrator, a fee not to exceed $500 for an examination under the Insurance Code §4151.201, and a filing fee not to exceed $200 for an annual report. The Insurance Code §4151.211(a) provides that a person may not acquire an ownership interest in an entity that holds a certificate of authority under the Insurance Code Chapter 4151 if the person is, or after the acquisition would be, directly or indirectly in control of the certificate holder, or otherwise acquire control of or exercise any control over the certificate holder, unless the

person has filed with the Department under oath a biographical form for each person by whom or on whose behalf the acquisition of control is to be effected; a statement certifying that no person who is acquiring an ownership interest in or control of the certificate holder has been the subject of a disciplinary action taken by a financial or insurance regulator of this state, another state, or the United State; a statement certifying that, immediately on the change of control, the certificate holder will be able to satisfy the requirements for the issuance of a certificate of authority; and any additional information that the Commissioner by rule may prescribe as necessary or appropriate to the public interest and the protection of the insurance consumers of this state. The Insurance Code §4151.211(b) provides that the Department may require a partnership, syndicate, or other group that is required to file a statement under the Insurance Code §4151.211(a) to provide the information required under the Insurance Code §4151.211(a) for each partner of the partnership, each member of the syndicate or group, and each person who controls the partner or member. Further, under the Insurance Code §4151.211(b), if the partner, member, or person is a corporation or the person required to file the statement under the Insurance Code §4151.211(a) is a corporation, the Department may require that the information required under the Insurance Code §4151.211(a) be provided regarding the corporation, each individual who is an executive officer or director of the corporation, and each person who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of the corporation. The Insurance Code §4151.211(c) provides that the Department may disapprove an acquisition of control if, after notice and opportunity for hearing, the Commissioner determines that immediately on the change of control the certificate holder would not be able to satisfy the requirements for the certificate of authority; the competence, trustworthiness, experience, and integrity of the persons who would control the operation of the certificate holder are such that it would not be in the interest of the insurance consumers of this state to permit the acquisition of control; or the acquisition of control would violate the Insurance Code or another law of this state, another state, or the United States. Notwithstanding the Insurance Code §4151.211(c), the Insurance Code §4151.211(d) provides that a change in control is considered approved if the Commissioner has not proposed to deny the requested change before the 61st day after the date on which the Department receives all information required by the Insurance Code §4151.211. The Insurance Code §4151.212 provides that the Department may, in the manner prescribed by the Insurance Code §4151.056 and by the Insurance Code Chapter 4151, Subchapter G revoke, suspend, or refuse to renew the certificate of authority of a certificate holder who does not maintain the qualifications necessary to obtain a certificate of authority issued under the Insurance Code Chapter 4151. The Insurance Code §4151.253(a) provides that an administrator shall enter into a contract in connection with workers' compensation benefits for collecting premium or contributions, adjusting claims, or settling claims with the insurance carrier responsible for those claims, including the insurance carrier responsible for claims arising under policies authorized under the Insurance Code §2053.202(b). Further, a contract required by the Insurance Code §4151.253(a) may be in the form of a master services agreement. The Insurance Code §4151.253(b) requires a contract required by the Insurance Code §4151.253(a) to provide that the contract does not limit in any way the insurance carrier's authority or responsibility, including financial responsibility, to comply with each statutory or regulatory requirement and that the administrator shall comply with each statutory or regulatory requirement relating to a function assumed by or carried out by the administrator. The Insurance Code §4151.257 provides that the Commissioner shall adopt rules to implement the requirements of the Insurance Code Chapter 4151, Subchapter F, including rules prescribing requirements for contracts and master services agreements and requirements for the payment of claims. Further, under the Insurance Code §4151.257, the rules must provide for compliance with the requirements of the Insurance Code Chapter 4151 for any contract that takes effect or has an annual anniversary date on or after January 1, 2008. The Insurance Code §4151.301 provides that the Department may deny an application for a certificate of authority or discipline the holder of a certificate of authority under the Insurance Code Chapter 4151, Subchapter G if the Department determines that the applicant or holder, individually, or through an officer, director, or shareholder has willfully violated an insurance law of this state; has intentionally made a material misstatement in the application for a certificate of authority; has obtained or attempted to obtain a certificate of authority by fraud or misrepresentation; has misappropriated, converted to the applicant's or holder's own use, or illegally withheld money belonging to an insurance carrier, as that term is defined by the Labor Code §401.011, an insurer, as that term is defined by the Insurance Code §4001.003, a health maintenance organization, or an insured, enrollee, injured employee, or beneficiary; has engaged in fraudulent or dishonest acts or practices; has materially misrepresented the terms and conditions of an insurance policy, certificate, evidence of coverage, or contract; has been convicted of a felony; is in a financial condition, or is operating or conducting business in a manner, that would render further transaction of business in this state hazardous or injurious to insured persons or the public; has failed to comply with any judgment rendered against the applicant or holder before the 60th day after the date on which the judgment becomes final; has willfully violated a Commissioner rule; has refused to be examined or to produce accounts, records, and files for examination as required by the Insurance Code Chapter 4151 or Commissioner rule; at any time fails to meet a qualification for which issuance of the certificate of authority could have been denied had the failure then existed and been known to the Commissioner; has had a certificate of authority, license, or other authority issued by this state, another state, or the United States suspended or revoked; or has failed to timely file the annual report required by the Insurance Code §4151.205.

The Labor Code Chapter 407 regulates workers' compensation self insurance. The Labor Code §407.001(5) defines a qualified claims servicing contractor as a person who provides claims service for a certified self-insurer, who is a separate business entity from the affected certified self-insurer, and who holds a certificate of authority under the Insurance Code Chapter 4151.

The Labor Code Chapter 407A regulates workers' compensation group self insurance. The Labor Code §407A.009(a) requires an administrator or service company under the Labor Code Chapter 407A that performs the acts of an administrator as defined in the Insurance Code Chapter 4151 to hold a certificate of authority under that chapter. The Labor Code §407A.009(b) provides that an entity is required to hold only one certificate of authority under the Insurance Code Chapter 4151 if the entity acts as an administrator and a service company as defined in the Labor Code Chapter 407A and performs the acts of an administrator as that term is defined in the Insurance Code Chapter 4151. The

Labor Code §407A.009(c) provides that the exemptions in the Insurance Code §4151.002(18), (19), and (20), apply to an administrator or service company under the Labor Code §407A.009. The Labor Code §415.0036(a) provides that the Labor Code §415.0036 applies to an insurance adjuster, case manager, or other person who has authority under the Labor Code, Title 5 to request the performance of a service affecting the delivery of benefits to an injured employee or who actually performs such a service, including peer reviews, performance of required medical examinations, or case management.

The Labor Code Chapter 415 addresses Texas Workers' Compensation Act administrative violations. The Labor Code §415.0036(b) provides that a person described by the Labor Code §415.0036(a) commits an administrative violation if the person offers to pay, pays, solicits, or receives an improper inducement relating to the delivery of benefits to an injured employee or improperly attempts to influence the delivery of benefits to an injured employee, including through the making of improper threats. The Labor Code §415.0036(b) provides that §415.0036 applies to each person described by §415.0036(a) who is a participant in the workers' compensation system of this state and to an agent of such a person.

The Education Code Chapter 22 regulates school district employees, including group health benefits for school employees. The Education Code §22.004(g) provides that an insurer, a company subject to the Insurance Code Chapter 842, or a health maintenance organization that issues a policy or contract under the Education Code §22.004 and any person that assists the school district in obtaining or managing the policy or contract for compensation shall provide an annual audited financial statement to the school district showing the financial condition of the insurer, company, organization, or person. The Education Code §22.004(h) provides that an audited financial statement provided under §22.004 must be made in accordance with rules adopted by the Commissioner of Insurance or with generally accepted accounting principles, as applicable.

The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§7.1613. Written Agreements Between Administrators and Insurers.

(a) An administrator may not provide administrative services in Texas on behalf of an insurer unless the administrator has entered into a written agreement with the insurer that meets the requirements of the Insurance Code Chapter 4151 and this section.

(b) An administrator subcontractor may meet the requirements of this section by entering into a written agreement with the administrator contractor only, provided the written agreement meets the requirements of the Insurance Code Chapter 4151 and this section, as applicable.

(c) A written agreement entered into under this section may not be construed to limit, in any way, an insurer's ultimate accountability and responsibility for compliance with all statutory and regulatory requirements under the Insurance Code, the Labor Code, and rules adopted thereunder.

(d) A written agreement entered into under this section shall include:

(1) a requirement that the administrator must comply with all statutory, contractual, and regulatory requirements related to a function assumed or carried out by the administrator and related to a plan for which the administrator performs or offers to perform administrative services;

(2) a description of the administrative services the administrator is expected to provide and any applicable instructions related to the performance of those services, including references to an insurer's claims handling practices or procedures;

(3) a provision relating to the continuity of services and addressing the obligations of the administrator and the insurer under §7.1615 of this subchapter (relating to Transfer of Books and Records), including the method and manner in which the insurer and administrator will meet those requirements; and

(4) a provision addressing an insurer's obligation to review and audit the performance of its administrators under §7.1611 of this subchapter (relating to Operational Review and On-Site Audit), including the method and manner in which the insurer will meet those requirements.

(e) A written agreement entered into under this section shall also ensure that the books and records of the insurer:

(1) remain the property of the insurer at all times; and

(2) are available to the insurer or its designee at any time while in the custody of the administrator.

(f) Notwithstanding subsection (e) of this section, an administrator may retain a proprietary interest in the books and records of an insurer pursuant to the Insurance Code §4151.113(c), provided that the written agreement between the administrator and the insurer specifically identifies the items that will be subject to the administrator's proprietary interest. An administrator may not withhold, based upon a claim of proprietary interest, any portion of an insurer's books and records that would restrict the ability of the insurer to comply with statutory, regulatory, or contractual obligations.

(g) A master services agreement may be used to meet the requirements of this section.

(h) If a particular requirement under this section does not apply to an administrative service offered or performed by an administrator on behalf of an insurer, that particular requirement may be omitted from the written agreement between the administrator and the insurer. However, the remainder of the written agreement between the administrator and the insurer must comply with the Insurance Code Chapter 4151 and this section.

(i) A written agreement required under this section shall meet the requirements of this section no later than September 1, 2009.

§7.1616. Hazardous or Injurious Operating Conditions.

(a) An applicant or administrator may be considered to be operating or conducting business in a hazardous or injurious manner if the administrator or applicant:

(1) has failed to file financial statements, documents, records, or reports required under the Insurance Code Chapter 4151 or this subchapter within the time periods prescribed by the Insurance Code Chapter 4151, this subchapter, or as requested by the department pursuant to law;

(2) has filed any false or misleading financial information;

(3) is unable to pay its obligations as they become due and payable;

(4) has not maintained records sufficient to permit examiners to determine its financial condition or compliance with the Insurance Code, the Labor Code, and rules adopted thereunder;

(5) does not employ management staff with the experience, competence, or trustworthiness to conduct its operations in a safe or sound manner;

(6) employs management staff that has engaged in any unlawful activity;

(7) has not complied or is not complying with the terms of a written agreement with an insurer, HMO, plan sponsor, or group;

(8) has engaged or is engaged in a pattern of failing to settle claims in accordance with contractual, regulatory, or statutory requirements; or

(9) has engaged or is engaged in fraudulent or dishonest practices or acts.

(b) Other facts and circumstances not specified in subsection (a) of this section, as determined by the commissioner, that relate to the financial condition or business operations or conduct of an applicant or administrator in this state may also indicate that an applicant or administrator is operating in a hazardous or injurious manner.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902272
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: June 25, 2009
Proposal publication date: December 5, 2008
For further information, please call: (512) 463-6327

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 11. TEXAS JUVENILE PROBATION COMMISSION

CHAPTER 341. TEXAS JUVENILE PROBATION COMMISSION STANDARDS

SUBCHAPTER I. ELECTRONIC DATA INTERCHANGE SPECIFICATIONS

37 TAC §341.60

The Texas Juvenile Probation Commission (TJPC) adopts the amendments made to §341.60, concerning the Commission's electronic data interchange specifications. This section is adopted without changes to the proposed text as published in the January 30, 2009, issue of the *Texas Register* (34 TexReg 525) and will not be republished.

TJPC adopts these amendments in an effort to reflect the accurate placement and services types that are currently available for juveniles.

No public comment was received.

These amendments are adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

No other code or article is affected by these new standards.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902235
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: June 25, 2009
Proposal publication date: January 30, 2009
For further information, please call: (512) 424-6710

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CHAPTER 344. EMPLOYMENT, CERTIFICATION AND TRAINING

The Texas Juvenile Probation Commission (TJPC or Commission) adopts new Chapter 344, §§344.100, 344.110, 344.120, 344.200, 344.210, 344.220, 344.230, 344.300, 344.310, 344.320, 344.330, 344.340, 344.400, 344.410, 344.500, 344.510, 344.520, 344.600, 344.610, 344.620, 344.630, 344.640, 344.650, 344.660, 344.670, 344.680, 344.700, 344.800, 344.810, 344.820, 344.830, 344.840, 344.850, 344.860, 344.870, 344.880, and 344.890, relating to employment, certification and training for juvenile officers. All sections, except for §344.310, are adopted without changes to the proposed text as published in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2480) and will not be republished. Section 344.310 is adopted with changes, because in subsection (e) the implementation date was changed from September 1, 2009 to January 1, 2010 to comply with the chapter's effective date.

TJPC adopts these rules in an effort to consolidate and streamline requirements related to employment, certification and training from several other chapters of the Commission's standards. This chapter also introduces several new requirements designed to enhance training and certification requirements for juvenile officers and to simplify the certification process.

No public comment was received regarding the new rules.

SUBCHAPTER A. DEFINITIONS AND APPLICABILITY

37 TAC §§344.100, 344.110, 344.120

These new rules are adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

No other code or article is affected by these new rules.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902246

Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 1, 2010
Proposal publication date: April 17, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER B. QUALIFICATIONS FOR EMPLOYMENT

37 TAC §§344.200, 344.210, 344.220, 344.230

These new rules are adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

The following rules and standards are affected by this subchapter: §349.7 and §341.20 of this title; and Human Resources Code §141.065.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200902247
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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Proposal publication date: April 17, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER C. CRIMINAL HISTORY SEARCHES

37 TAC §§344.300, 344.310, 344.320, 344.330, 344.340

These new rules are adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

The following rules and standards are affected by this subchapter: §§349.8, 343.302, 343.304, and 343.306 of this title.

§344.310. Criminal History Searches for Positions Not Requiring Certification.

(a) Criminal history searches shall be conducted for all personnel providing services in juvenile justice facilities or programs who may have direct unsupervised access to juveniles in the facility or program. Prior to being granted access to juveniles in facilities or programs, criminal history searches shall be completed for the following:

(1) Non-Certified Staff. The chief administrative officer or designee shall conduct criminal history searches in accordance with the requirements set forth in §344.300 of this chapter for staff employed full or part-time by a juvenile justice program or juvenile justice facility in positions that do not require certification.

(2) Volunteers and Interns. The chief administrative officer or designee shall conduct criminal history searches in accordance with the requirements set forth in §344.300 of this chapter for volunteers and interns who provide services in juvenile justice programs and facilities.

(3) Service Providers. Service providers include public or private vendors who provide goods and/or services for the operation, management or administration of juvenile probation services and juvenile justice programs and facilities.

(A) Licensed Service Providers. Programs or facilities licensed by the Texas Department of Family and Protective Services, Texas Department of State Health Services or other state agency are exempt from the requirement to provide documentation of criminal history searches for staff employed in the program or facility. The chief administrative officer or designee shall obtain documentation confirming that the provider's license is in good standing with the licensing entity. The facility or program shall not contract for services with a provider whose license is not in good standing.

(B) Non-Licensed Service Providers. The chief administrative officer or designee shall obtain documentation from the provider's employing entity confirming that fingerprint-based criminal history searches of criminal information databases maintained by the Federal Bureau of Investigation and by the state of Texas have been completed within two years prior to the date of the most recent contract for services.

(b) Department policy shall prohibit direct unsupervised access to juveniles in a juvenile justice program or facility by any person with a disqualifying criminal history as described in §344.400 of this chapter.

(c) The juvenile board may grant an exemption to subsection (b) of this section for personnel described in this subsection whose criminal history report reflects class B misdemeanor activity. Exemptions shall be reviewed and granted on a case-by-case basis.

(d) The requirements of this section do not apply to the juvenile's attorney, family members or other individuals listed as a juvenile's approved visitors.

(e) The criminal history searches described in this section shall apply to individuals who begin employment or service provision on or after January 1, 2010.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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Proposal publication date: April 17, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER D. DISQUALIFYING CRIMINAL HISTORY

37 TAC §344.400, §344.410

These new rules are adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

The following rules and standards are affected by this subchapter: §§349.7, 349.10, 341.23, and 343.320 of this title.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200902249
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
Effective date: January 1, 2010
Proposal publication date: April 17, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER E. EDUCATION REQUIREMENTS FOR EMPLOYMENT AND CERTIFICATION

37 TAC §§344.500, 344.510, 344.520

These new rules are adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

No other code or article is affected by these new rules.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200902250
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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SUBCHAPTER F. TRAINING AND CONTINUING EDUCATION

37 TAC §§344.600, 344.610, 344.620, 344.630, 344.640, 344.650, 344.660, 344.670, 344.680

These new rules are adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

No other code or article is affected by these new rules.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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Proposal publication date: April 17, 2009
For further information, please call: (512) 424-6710

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SUBCHAPTER G. COMPETENCY EXAMINATION

37 TAC §344.700

This new rule is adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

No other code or article is affected by this new rule.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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SUBCHAPTER H. CERTIFICATION

37 TAC §§344.800, 344.810, 344.820, 344.830, 344.840, 344.850, 344.860, 344.870, 344.880, 344.890

These new rules are adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

The following rule is affected by this subchapter: §349.8 of this title.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200902253
Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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CHAPTER 350. INVESTIGATING ABUSE, NEGLECT, EXPLOITATION, DEATH AND SERIOUS INCIDENTS

37 TAC §§350.100, 350.110, 350.120, 350.200, 350.210, 350.300, 350.400, 350.500, 350.600, 350.610, 350.620, 350.700, 350.800, 350.900 - 350.904

The Texas Juvenile Probation Commission (Commission or TJPC) adopts new Chapter 350, §§350.100, 350.110, 350.120, 350.200, 350.210, 350.300, 350.400, 350.500, 350.600, 350.610, 350.620, 350.700, 350.800, and 350.900 - 350.904, relating to investigating abuse, neglect, exploitation, death and serious incidents by the Texas Juvenile Probation Commission. Sections 350.110, 350.120, 350.200, 350.210, 350.300, 350.400, 350.500, 350.600, 350.610, 350.620, 350.700, 350.800, and 350.900 - 350.904 are adopted without changes to the proposed text as published in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2490) and will not be republished. Section 350.100 is adopted with changes to the proposed text as published. In §350.100(b)(7), the definition of Call Line is clarified.

TJPC adopts these rules in an effort to ensure that the agency's investigators have the ability to conduct comprehensive investigations in a more timely and efficient manner.

Public comment was received relating to the purpose of the new chapter. The comment was that it appears that the purpose of this new chapter is to replace §§349.43 - 349.52 and §§349.57 - 349.64 and that the standards currently laid out in Chapter 349 are more specific. If this new Chapter 350 is meant to replace current standards, than it would be prudent to table this chapter until the proposed revisions to Chapter 349 are posted. The Texas Juvenile Probation Commission rejects this proposal. Chapter 350 pertains to investigations conducted by the Commission and is intended only to replace §§349.42- 349.51. Chapter 350 does not contain provisions relating to the disciplinary processes; and therefore, has no bearing on §§349.21 - 349.32.

Public comment was received on §§350.900 - 350.903. Specifically, the comment was that these sections deal with the training of abuse investigators, yet they fail to spell out any specifics or minimum requirements. It was recommended that the Texas Juvenile Probation Commission designate a number of hours for both initial and continuing education. In addition, it was suggested to request that each investigator have a current certification in at least one of the Texas Juvenile Probation Commission's approved restraint techniques. If the investigators are to determine whether a restraint was conducted properly, it would be prudent for them to have some expertise in the area. The Texas Juvenile Probation Commission rejected these suggestions. The specific requirements relating to training and the continuing education of Commission investigators are contained in the unit's policy and procedure manual. All but one of the Commission's investigators have previous training, including instructor level certification, and hands-on experience in Crisis Prevention Institute and Handle with Care. Recently, four of the six investigators received instructor level certification in Handle with Care. In addition, trainings are being scheduled with the remaining restraint technique providers.

These new rules are adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

No other code or article is affected by these new sections.

§350.100. Definitions.

(a) The terms used in this chapter apply to the investigations of alleged abuse, neglect, exploitation, death conducted by the Commission and to the Commission's procedures relating to serious incidents.

(b) Terms used in this chapter shall have the following meanings unless otherwise expressly defined within the chapter.

(1) Abuse, Neglect and Exploitation--The definitions of "abuse", "neglect" and "exploitation" shall have the meanings ascribed under Texas Family Code §261.001 and §261.401. For the purposes of this chapter, "abuse" includes serious physical abuse and sexual as defined in this section.

(2) Administrator--The chief administrative officer of a juvenile probation department, a public or private juvenile justice program or a public or private juvenile justice facility.

(3) Administrative Designee--The role assigned to the administrator, when a preponderance of evidence determines that the proximate cause of the allegation was based on policies and procedures under the direct control of the administrator.

(4) Alleged Perpetrator--A person alleged as being responsible for the abuse, neglect or exploitation of a juvenile through the person's actions or failure to act.

(5) Alleged Victim--A juvenile under the jurisdiction of the juvenile court or participating in a program operated under the authority of the governing board or juvenile board who is alleged to be a victim of abuse, neglect or exploitation.

(6) Attempted Suicide--Any voluntary and intentional action that could reasonably result in taking one's own life.

(7) Call Line--The toll-free number made available for reporting allegations of abuse, neglect, exploitation, death and serious incidents within the juvenile justice system.

(8) Commission--The Texas Juvenile Probation Commission.

(9) Designated Perpetrator--The individual responsible for the abuse, neglect or exploitation of a juvenile who has not exhausted the right to administrative review or whose right to administrative review has not expired.

(10) Designated Victim--The juvenile who was abused, neglected or exploited.

(11) Escape--

(A) The voluntary, unauthorized departure, or attempt to depart, by an individual who is in custody; or

(B) Failure to return to custody following an authorized temporary leave for a specific purpose or limited period.

(12) Incident Report Form--The required form used to report to the Commission alleged abuse, neglect, exploitation, death and serious incidents.

(13) Internal Investigation Report--The written report submitted to the Commission that summarizes the steps taken and the evidence collected during an internal investigation of alleged abuse, neglect, exploitation or death.

(14) Juvenile--A person who is under the jurisdiction of the juvenile court, confined in a juvenile justice facility, or participating in a juvenile justice program.

(15) Juvenile Justice Facility ("facility")--A facility, including its premises and all affiliated sites, whether contiguous or detached, operated wholly or partly by or under the authority of

the governing board, juvenile board or by a private vendor under a contract with the governing board, juvenile board or governmental unit that serves juveniles under juvenile court jurisdiction. The term includes, but is not limited to:

(A) A public or private juvenile pre-adjudication secure detention facility, including a short-term detention facility (i.e., holdover) required to be certified in accordance with Texas Family Code §51.12;

(B) A public or private juvenile post-adjudication secure correctional facility required to be certified in accordance with Texas Family Code §51.125, except for a facility operated solely for children committed to the Texas Youth Commission; and

(C) A public or private non-secure juvenile post-adjudication residential treatment facility housing juveniles under juvenile court jurisdiction.

(16) Juvenile Justice Program ("program")--A program or department operated wholly or partly by the governing board, juvenile board or by a private vendor under a contract with the governing board, or juvenile board that serves juveniles under juvenile court jurisdiction or juvenile board jurisdiction. The term includes a juvenile justice alternative education program and a non-residential program that serves juvenile offenders under the jurisdiction of the juvenile court or juvenile board jurisdiction and a juvenile probation department.

(17) Juvenile Probation Department ("department")--All physical offices and premises utilized by a county or district level governmental unit established under the authority of a juvenile board(s) to facilitate the execution of the responsibilities of a juvenile probation department enumerated in Title 3 of Texas Family Code and Chapter 141 of Texas Human Resources Code.

(18) Peace Officer--A person elected, employed, or appointed as a peace officer under Code of Criminal Procedure, Article 2.12.

(19) Report--Formal notification to the Commission of alleged abuse, neglect, exploitation or death or of a serious incident.

(20) Reportable Injury--Any injury sustained accidentally, intentionally, recklessly or otherwise that:

(A) Requires medical treatment as defined in this section; or

(B) Results from a personal, mechanical or chemical restraint and is a substantial injury as defined in this section.

(21) Serious Incident--Attempted escape, attempted suicide, escape, reportable injury, youth-on-youth physical assault or youth sexual conduct as defined in this section.

(22) Serious Physical Abuse--Bodily harm or condition that resulted directly or indirectly from the conduct that formed the basis of an allegation of abuse, neglect or exploitation, if the bodily harm or condition requires medical treatment as defined in this section.

(23) Sexual Abuse--Conduct committed by any person against a juvenile that includes sexual abuse by contact or sexual abuse by non-contact. A juvenile, regardless of age, may not affirmatively or impliedly consent to the acts as defined in this section under any circumstances.

(24) Sexual Abuse by Contact--Any physical contact with a juvenile that includes: intentional touching of the genitalia, anus, groin, breast, inner thigh or buttocks with the intent to abuse, intimidate, hurt, humiliate or harass, arouse or gratify sexual desire; deviate sexual intercourse; sexual contact; sexual intercourse; or sexual performance as those terms are defined in subparagraphs (A) - (D) of this paragraph.

(A) "Deviate sexual intercourse" means:

(i) any contact between any part of the genitals of one person and the mouth or anus of another person; or

(ii) the penetration of the genitals or the anus of another person with a hand, finger or other object.

(B) "Sexual contact" means the following acts, if committed with the intent to arouse or gratify the sexual desire of any person:

(i) any touching by a person, including touching through clothing, of the anus, breast, or any part of the genitals of a person; or

(ii) any touching of any part of the body of a person, including touching through clothing, with the anus, breast, or any part of the genitals of a person.

(C) "Sexual intercourse" means any penetration of the female sex organ by the male sex organ.

(D) "Sexual performance" means acts of a sexual or suggestive nature performed in front of one or more persons including simulated or actual sexual intercourse, deviate sexual intercourse, bestiality, masturbation, sado-masochistic abuse or lewd exhibition of the genitals, the anus, or any portion of the female breast below the top of the areola.

(25) Sexual Abuse by Non-Contact--Any sexual behavior, conduct, harassment or actions other than those defined by sexual abuse by contact, which are exhibited, performed or simulated:

(A) in the presence of a juvenile or with reckless disregard for the presence of a juvenile;

(B) with the intent to arouse or gratify the sexual desire of any person;

(C) with the intent to intimidate, hurt, humiliate or harass any person;

(D) including repeated verbal statement or comments of a sexual nature; and

(E) including demeaning references to gender, derogatory comments about body or clothing or profane or obscene language or gestures.

(F) These behaviors, conduct and actions include indecent exposure, voyeurism, distribution or exhibition of pornographic or sexually explicit material or sexual performance as defined in paragraph (24)(D) of this subsection.

(26) Substantial Injury--An injury that is significant in size, degree or severity.

(27) Sustained Perpetrator--A designated perpetrator as defined in this section who has already been offered the right to an administrative review and the designated perpetrator's rights to the administrative review have expired or the disposition was upheld.

(28) TCLEOSE--Texas Commission on Law Enforcement Officer Standards and Education.

(29) Youth-on-Youth Physical Assault--A physical altercation between two or more juveniles that results in any of the involved parties sustaining an injury that requires medical treatment as defined in this section.

(30) Youth Sexual Conduct--Two or more juveniles, regardless of age, who engage in deviate sexual intercourse, sexual contact, sexual intercourse, sexual performance as those terms are defined in paragraph (24) of this subsection or sexual behavior, conduct or actions which are exhibited, performed or simulated as those terms are defined in paragraph (25) of this subsection. A juvenile may not consent to the acts as defined in this section under any circumstances. Consent may not be implied regardless of the age of the juvenile.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Lisa A. Capers
Deputy Executive Director and General Counsel
Texas Juvenile Probation Commission
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For further information, please call: (512) 424-6710

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CHAPTER 358. IDENTIFYING, REPORTING AND INVESTIGATING ABUSE, NEGLECT, EXPLOITATION, DEATH AND SERIOUS INCIDENTS

37 TAC §§358.100, 358.120, 358.140, 358.200, 358.220, 358.300, 358.320, 358.400, 358.420, 358.440, 358.460, 358.480, 358.500, 358.600, 358.620, 358.640, 358.660, 358.680, 358.700, 358.720, 358.740, 358.760, 358.780, 358.800, 358.820, 358.840, 358.900, 358.920

The Texas Juvenile Probation Commission (TJPC or Commission) adopts new Chapter 358, §§358.100, 358.120, 358.140, 358.200, 358.220, 358.300, 358.320, 358.400, 358.420, 358.440, 358.460, 358.480, 358.500, 358.600, 358.620, 358.640, 358.660, 358.680, 358.700, 358.720, 358.740, 358.760, 358.780, 358.800, 358.820, 358.840, 358.900, and 358.920, relating to identifying, reporting and investigating abuse, neglect, exploitation, death and serious incidents in departments, programs and facilities. The sections are adopted without changes to the proposed text as published in the April 17, 2009, issue of the *Texas Register* (34 TexReg 2493) and will not be republished.

TJPC adopts these new rules in an effort to provide the departments, programs and facilities more comprehensive and well-formulated guidelines for identifying and reporting allegations of abuse, neglect and exploitation.

Public comment was received and the question was why was TJPC collecting the information referenced in §358.220(c)(4). TJPC's response is that this information is collected to help ensure that the correct person is properly identified. If we have multiple persons with the same name (e.g., John Doe) in our system, we need an identifier to distinguish one from the other.

Public comment was received to define experience or training as required under §358.700(a). TJPC's response is that the Compliance Resource Manual will contain more specific and clarifying language. It is the Commission's goal to incrementally increase the qualifications required for internal investigators, however, implementing too many specific requirements at this point would be a hardship.

Public comment was received and the question was asked if TJPC is going to inform the hiring agency of a pending investigation in another jurisdiction under §358.720(b) - (c). TJPC's response is that subsection (b) directs the county to notify the Commission and subsection (c) directs the jurisdiction conducting the investigation to communicate with the jurisdiction who hired the person under investigation.

Public comment was received and wanted to know about garrity issues related to §358.840(b)(1) - (4). TJPC's response is that garrity issues are not applicable because the Commission is not the employer. There is no requirement of self-incrimination, only that the person cooperates with the investigation.

Public comment was received on §358.920(a)(2) and the question was asked how are people going to remember to redact names of staff if dispositions are "ruled out." TJPC's response is that the onus is on the alleged perpetrator to submit the request, which is consistent with all similar statutes.

Public comment was received on §358.500(a) - (b). It was recommended that all reporting times remain consistent and that the reporting times remain at the current 24 hours. This should also apply to §358.600. TJPC's response is that the varied reporting times are tied to the severity of the allegations. In these particular situations it is important that law enforcement and the Commission have more timely notifications in order to facilitate the more rapid initiation of the investigation process, which will also help preserve the integrity of evidence.

Public comment was received on Chapter 358 that the standards subject employees to unnecessary and unwarranted discipline after such matters have been dealt with in the department in which they are employed and threatens their future employment and licensing unnecessarily. TJPC's response is that the provisions relating to administering discipline against certified officers is contained in §§349.21 - 349.32. Chapter 358 does not contain provisions relating to the disciplinary processes and pertains to the identifying, reporting and investigating allegations of abuse, neglect, exploitation, death and serious Incidents at the local level. Chapter 358 is intended only to replace those same provisions as they currently exist in §§341.15, 343.3, 348.16, 348.17 and 351.3.

These new rules are adopted under §141.042 of the Texas Human Resources Code, which provides the Texas Juvenile Probation Commission with rulemaking authority.

No other code or article is affected by these new sections.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 5, 2009.

TRD-200902255
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Texas Juvenile Probation Commission
Effective date: September 1, 2009
Proposal publication date: April 17, 2009
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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 20. TEXAS WORKFORCE COMMISSION

CHAPTER 809. CHILD CARE SERVICES
SUBCHAPTER C. ELIGIBILITY FOR CHILD CARE SERVICES

40 TAC §809.41

The Texas Workforce Commission (Commission) adopts amendments to the following section of Chapter 809, relating to Child Care Services, without changes, as published in the December 12, 2008, issue of the *Texas Register* (33 TexReg 10146):

Subchapter C. Eligibility for Child Care Services, §809.41

PART I. PURPOSE, BACKGROUND, AND AUTHORITY

PART II. EXPLANATION OF INDIVIDUAL PROVISIONS WITH COMMENTS AND RESPONSES

PART I. PURPOSE, BACKGROUND, AND AUTHORITY

Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, as amended, requires that providers of federal public benefits verify the citizenship or immigration status of all beneficiaries of public assistance. The Child Care and Development Fund (CCDF) is among the U.S. Health and Human Services programs that are subject to the verification provisions of PRWORA. On November 25, 1998, the Administration for Children and Families (ACF) issued Program Instruction ACYF-PI-CC-98-08 to clarify that the child is the primary beneficiary of the CCDF program and as such *only the child's* citizenship or immigration status is subject to verification.

PRWORA §432(d), as amended, exempts nonprofit charitable organizations that provide federal, state, or local public benefits from determining, verifying, or otherwise requiring proof of citizenship or immigration status from any applicant for such benefits. In Program Instruction ACYF-PI-CC-98-08, ACF affirmed that this exemption is applicable when nonprofit charitable organizations determine eligibility for CCDF, but *not* applicable when governmental entities or nonprofits that are not charitable organizations determine eligibility. Additionally, the CCDF Lead Agency cannot require nonprofit charitable organizations determining eligibility for the CCDF program to verify citizenship and immigration status.

Texas Labor Code §302.023 requires that the administration of workforce development programs be delegated to the Local Workforce Development Boards (Boards) and Texas Government Code §2308.264(a) prohibits Boards from directly determining eligibility for services. As a result, child care eligibility is determined by entities that contract with Boards--a majority of which are nonprofit charitable organizations. ACF guidance in ACYF-PI-CC-98-08 did not specify whether the CCDF Lead Agency contracting with nonprofit charitable organizations--which are exempt from verifying a child's citizenship or immigration status--retains the responsibility for ensuring that such verification is conducted.

On May 2, 2008, ACF issued Program Instruction CCDF-ACF-PI-2008-01 to clarify its previous guidance and respond to inquiries from a number of states regarding verification of citizenship or immigration status of CCDF applicants. The Program Instruction states that while nonprofit charitable organizations are exempt from the verification requirements mandated by Title IV of PRWORA, the CCDF Lead Agency is not exempt from its responsibility to ensure that only eligible individuals receive services. Therefore, when contracting directly or indirectly with a nonprofit charitable organization that elects not to verify the citizenship or immigration status of applicants for CCDF services, the Texas Workforce Commission, as the CCDF Lead Agency, remains responsible for ensuring that a child's citizenship and immigration status is verified.

As a result of this clarification, the Commission adopts amendments to Chapter 809, Child Care Services rules, to ensure that a child's citizenship or legal immigrant status is verified as part of the basic eligibility determination for CCDF services.

PART II. EXPLANATION OF INDIVIDUAL PROVISIONS WITH COMMENTS AND RESPONSES

SUBCHAPTER C. ELIGIBILITY FOR CHILD CARE SERVICES

The Commission adopts the following amendment:

§809.41. A Child's General Eligibility for Child Care Services

New §809.41(a)(2) is added to require that Boards must ensure that a child's citizenship or legal status is verified as a component of eligibility for child care services.

This change reflects guidance from ACF that a child's citizenship or immigration status must be verified to comply with PRWORA requirements.

Pursuant to §809.42(a), prior to authorizing child care a Board must ensure that its child care contractor verifies eligibility for child care services, which includes a child's citizenship or immigration status. Program Instruction CCDF-ACF-PI-2008-01 states that Lead Agencies have flexibility to establish procedures for verifying an applicant's citizenship or immigration status. However, the procedures must be in accordance with U.S. Department of Justice (DOJ) requirements for verifying eligibility for "Federal public benefit" programs found in the November 17, 1997, DOJ "Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996." (62 FR 61344).

To comply with the federal directive in Program Instruction CCDF-ACF-PI-2008-01 in a timely manner, on December 8, 2008, the Commission issued Workforce Development (WD) Letter 44-08, entitled "Child Care Services: Documentation of a Child's Age, Citizenship, or Immigration Status" to provide Boards with guidance on methods for verifying a child's citizenship or immigration status that comply with DOJ guidance.

Also, because some child care contractors are nonprofit charitable organizations and exempt from verifying citizenship or immigration status under PRWORA §432(d), the Commission will also issue guidance to Boards that maintains this exemption but ensures that the verifications are performed.

Certain paragraphs in §809.41 have been renumbered to accommodate additions or deletions.

Comment: Four commenters believed that the ACF program instruction of 2008, on which the Commission based the proposed rule, is inconsistent with the DOJ interim guidance provided in

1997, which states that nonprofit charitable organizations cannot be required to verify citizenship.

Response: The Commission takes no position regarding the contention that there may be an inconsistency between the 1997 DOJ interim guidance and the ACF guidance issued in May 2008. As the Lead Agency responsible for administering the CCDF program and funds, the Commission must comply with all directives issued by ACF regarding CCDF program and funds. In particular, the Commission must ensure that CCDF funds are spent in the manner determined by ACF and applicable federal laws. ACF affirmed in CCDF-ACF-PI-2008-01 that nonprofit charitable organizations are exempt from citizenship verification requirements. However, Lead Agencies are not exempt and must ensure that the verifications are performed. The Commission affirmed this exemption in §809.41(a)(2) and in WD Letter 44-08 to ensure that Boards and their child care contractors comply with the nonprofit charitable organization exemption.

Comment: Two commenters suggested that the Commission withdraw the proposed rule. One commenter suggested that the Commission wait until the new White House administration issues further guidance.

Response: As Lead Agency responsible for administering the CCDF program, the Commission must comply with all ACF directives regarding CCDF. The Commission does not have the authority to choose which federal guidance to implement and which federal guidance to leave pending in anticipation of possible changes from a new administration.

Comment: One commenter questioned why the rule was being changed as ACF had not threatened Lead Agencies with loss of funding. As such, there is no rush to act. The commenter believed that before ACF could threaten an agency with "pulling funds," there must be a determination of improper payments.

Response: The Commission disagrees with the assumption that it should wait to be threatened with loss of funding before acting. The Commission will always respond to directives and guidance from federal agencies and address any issue to ensure that federal funds are spent properly. This includes complying with the ACF guidance on verifying a child's citizenship and immigration status.

Comment: One commenter believed that Texas influenced ACF to issue guidance on citizenship. The commenter pointed out that ACF did not issue the guidance in 2008 until after requested to do so by the Agency.

Response: The Commission disagrees with the comment. ACF specifically notes in its guidance that the purpose is to "clarify(y) previous policy guidance and respond to inquiries received from a number of States regarding verification of the citizenship and immigration status of CCDF applicants." Moreover, the action corresponds with ACF's efforts to reduce improper payments in subsidized child care and other federally funded programs. ACF's requirements for implementing the "Improper Authorizations for Payment Report" specified that the citizenship or immigration status of the child must be contained in the case file or the case file would be considered as missing a required data element for determining eligibility; and, thus, would constitute an error and possible improper payment. The Agency, along with other states, requested clarification from ACF to ensure compliance with the data requirement of the "Improper Authorizations for Payment Report."

Comment: One commenter stated that the Commission rules would have the effect of prohibiting a charitable nonprofit from receiving a contract with the Board to determine child care eligibility.

Response: The Commission disagrees with the comment. Charitable nonprofits are not exempt from the majority of the eligibility requirements, and have raised no concerns about ability or willingness to perform those functions. The child care eligibility determination process consists of verifying: 1) the parent's eligibility requirements including verifying the family income and the parent work status or participation in education or job training activities; and 2) the child's eligibility requirements such as the child's age and U.S. citizenship or legal immigration status. As the ACF guidance clarified, charitable nonprofits are not required to verify citizenship or immigration status of the child, a subset of the entire eligibility verification process. However, as the CCDF Lead Agency, the Commission has the responsibility to see that this determination is still performed if a charitable nonprofit is unwilling to do so, and pass this requirement on to the Boards.

Accordingly, when Boards undertake a competitive procurement process for child care eligibility determinations, they must procure for all elements of eligibility verification. When selecting the entity or entities, the Board takes into consideration contractor qualifications, service offerings, as well as the total overall cost to the Board of conducting both parts of the eligibility process (parent eligibility and child eligibility). If a charitable nonprofit organization declines to verify citizenship or immigration status directly, but offers to subcontract that service to another entity as part of its procurement bid, then the Board will take that into consideration in evaluating the bid, just as if a single entity provided both portions of eligibility determination. However, if a charitable nonprofit organization declines to include that service in its bid, that bid would be considered nonresponsive to the Board's request, consistent with procurement guidelines. Unless a Board separately procures each element of eligibility verification, allowing the Board to contract with separate entities to ensure the full verification is conducted, the bid of a charitable nonprofit choosing not to perform all elements requested would not be considered responsive. In either case, the Board will attempt to contract out the eligibility process to provide the lowest cost to the Board and ultimately to the state.

Selecting a single contractor or a combination of contractors to perform all of the eligibility services listed in a request for proposal over a contractor that can perform only some of the services does not constitute a penalty.

Comment: One commenter stated that allowing a Board to take into consideration in awarding a child care contract an entity's willingness or ability to document citizenship or immigration status has the practical result of penalizing a charitable nonprofit. The commenter stated that this is in conflict with the DOJ interim guidance, which states that a charitable nonprofit choosing not to document citizenship should not be penalized for providing public benefits to an individual who is not a U.S. citizen or legal immigrant except when it does so in violation of independent program verification requirements or in the face of a verification determination made by a nonexempt entity.

Response: The Commission disagrees that the Agency's rules implementing ACF directives in any way penalize charitable nonprofit entities. The comment correctly cites the DOJ interim guidance statement that a charitable nonprofit that does not document citizenship should not be penalized for providing public benefits to an individual who is not a U.S. citizen or legal immi-

grant. The comment also correctly states that the charitable nonprofit may be penalized if it provides public benefits to an individual who is not a U.S. citizen or legal immigrant when it does so in violation of "independent program verification requirements." As the Lead Agency, the Agency must ensure that charitable nonprofit entities are afforded the ACF exemption, while at the same time, ensure that public benefits are not provided to an ineligible individual. It is important to note that, in Texas, determining child care eligibility is an independent process, separate and distinct from providing subsidized child care services. Boards contract with entities, some of which may be charitable nonprofits, to determine eligibility. Once eligibility is determined by the entity, the parent chooses a child care provider. The entity determining eligibility follows the Agency's and the Board's "independent program verification requirements" and makes referrals to child care providers based on the parent choice of provider. Accordingly, the risk of providing public benefits to ineligible individuals must be addressed at the eligibility determination stage.

Comment: One commenter noted that a Board wrote a letter to the Agency during rule development stating that the rule would place additional costs on the Boards at a time when the Boards are trying to decrease administrative and operational expenditures. The commenter expressed concerns that this rule would add stress to an already stretched and stressed system.

Response: The Commission disagrees that the rule would place stress on the child care system. As mentioned in the impact statements of the proposed rules (as published in the December 12, 2008, issue of the *Texas Register* (33 TexReg 10146)), any costs associated with implementing the rules are not likely to be significant, particularly when such verification can occur using the same documentation currently used to verify the child's age. Additionally, citizenship and immigration status verification for child care is a one-time procedure per child compared to parental working status and income level, which may be verified as many as four times per year. Finally, the verification also may be satisfied through the required verification process associated with other federal assistance programs, such as qualification for Temporary Assistance for Needy Families or Supplemental Nutrition Assistance Program benefits, prior to qualification for subsidized child care.

Comment: One commenter stated that the explanations for implementing §809.41(a)(2) in WD Letter 44-08 include elements that are inconsistent with the federal law and DOJ guidance. Specifically, the letter did not include in the list of acceptable verification documents the ability of the parent to provide a written declaration under penalty of perjury from one or more third parties or the applicant's written declaration under penalty of perjury as allowed under DOJ's Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility under Title IV of PRWORA.

Response: The Commission notes that the documentation requirements provided in WD Letter 44-08 were taken directly from the DOJ guidance. Program Instruction CCDF-ACF-PI-2008-01 gives Lead Agencies flexibility to establish procedures for verifying an applicant's citizenship or immigration as long as they comply with the DOJ interim guidance. The Commission points out that the written declaration referenced in DOJ's guidance is accompanied by an additional requirement that the citizenship and immigration status be verified.

The DOJ interim guidance allows the option for the required verification to be a document verifying citizenship or a written declaration. The DOJ guidance also states that the written declaration presents "a greater potential for undetected false claims of being a United States citizen or non-citizen national, and therefore should be used with caution in appropriate circumstances." Additionally, although the DOJ guidance allows a written declaration from a qualified alien, the DOJ interim guidance also states that the individual should be asked to provide documentation to verify the legal immigration status. Therefore, the Commission contends that the process set out in Agency rules for determining U.S. citizenship or legal immigrant status conforms with DOJ interim guidance.

Comment: One commenter stated that "public safety is enhanced when public needs are effectively met." The commenter asked that the focus be on "productivity, efficiency, economy, and making sure that needs are met with the limited funds that we have." The commenter noted that its organization sometimes finds "lots of overlap, fragmentation, and duplication" in nonprofit agencies. The commenter suggested that no action be taken.

Response: The Commission agrees that productivity, efficiency, and economy are important factors. One reason Boards have the flexibility to take into consideration an entity's willingness or ability to provide full verification, including documenting a child's citizenship or immigration status, is to prevent the type of concerns mentioned in the comment such as overlap, fragmentation, and duplication. These problems could occur if a Board is forced to split the eligibility determination between two contractors. However, the Commission disagrees that the best course is to take no action. The DOJ guidance long ago established that nonprofits do not have to verify citizenship or immigration status. The ACF guidance simply clarified that while that is true, citizenship must still be verified by someone in order for a child to be entitled to receive subsidized child care, and the Lead Agencies are responsible for ensuring that this is done.

Comment: Two commenters expressed concern for immigrants who have experienced dire circumstances to get into the United States and those who have had to overcome the language and cultural barriers to get assistance. One commenter mentioned that many have fled severe abuse and are able to stay because they are asylees, refugees, or victims under the Violence Against Women Act. The commenter explained that the immigrants would once again suffer great hardship because of resulting delays if they were to have their identification lost or stolen and were unable to prove their immigration status to receive child care. The commenter added that the process would be cumbersome for a child care-providing organization to understand the complexity of the documents to accept.

Response: The Commission recognizes dedication of advocates who assist immigrants. The Commission's intent is to ensure that federal and state funds are expended on those eligible to receive subsidized care. It is important to remember that it is only the child's citizenship or immigration status--not the parent's--that must be verified. This guidance has been provided to the Boards in WD Letter 44-08, which includes a list of acceptable documents, taken from DOJ guidance, to verify a child's citizenship or immigration status and age.

The Commission notes that the eligibility verification process applies to all families and is conducted regardless of immigrant status. All individuals in need of child care services share common traits and the need for immediate services is one of them. The Texas workforce system strives to provide service as promptly as possible, as long as the eligibility determination is completed in compliance with federal and state regulations. The Commission does not believe that it would be any more complex to ask for

verification of the child's citizenship or immigration status than it would be to ascertain the family's income eligibility or the child's age.

Finally, the Commission understands the concern that child care providers may have difficulty understanding the complexity of the acceptable documents for verifying citizenship. However, the Commission again points out that the actual providers of child care are not responsible for verifying citizenship and immigration status. As mentioned previously, in Texas, determining eligibility for subsidized child care is an independent process that is separate from providing child care services. Once eligibility is determined by the Board's child care contractor, the parent chooses a child care provider. The child care provider is not responsible for determining eligibility and will not be required to understand the documents necessary for verifying the child's citizenship or immigration status. The task of verifying the correct documents is left to the child care contractor and not the child care provider.

Comment: One commenter stated that there is a discriminatory impact and violation of Texas Government Code §2105.004, which states that "(a)n agency or provider may not use block grant funds in a manner that discriminates on the basis of race, color, national origin, sex, or religion." The commenter stated that "no children at all should be kept from receiving child care from a nonprofit charitable organization for lack of verification."

Response: The Commission appreciates the desire for all children to receive care irrespective of their status. The Commission disagrees that the proposed rule violates the cited statute. The proposed rule has neither a discriminatory intent nor effect. Federal regulation as clarified through ACF guidance requires Lead Agencies to verify a child's age and citizenship or immigration status before the child can receive subsidized child care. This is part of the eligibility process and is applied uniformly to all children. As long as the child's age and status are verified and the family's income level falls within the Board-established limits, then a child is eligible for care. It does not matter where the child was born.

Comment: One commenter asked why both the ACF guidance and the proposed rule do not mention the statement found in DOJ guidance at 62 C.F.R. §61349 that an applicant cannot be conclusively denied benefits without first verifying the applicant's status with the U.S. Citizenship and Immigration Services' guidelines. The commenter then noted that the DOJ guidance followed that statement with a series of complex steps for verifying citizenship and immigration status. The commenter stated that these steps were also not mentioned in the Commission rules.

Response: The Commission notes that the DOJ statement referenced in the comment, when taken in context of the DOJ guidance, applies to cases in which the document presented does not on its face reasonably appear to be genuine or to relate to the person presenting it. The Commission also points out that the comment failed to include the related statement in the DOJ guidance that the entity determining eligibility:

"should refer to the legal requirements of your program and to any applicable guidance provided by the federal agency or department overseeing your program, if any, to determine whether you would grant or withhold benefits during the period of time in which you are verifying the applicant's immigration status."

ACF, the federal agency overseeing subsidized child care, has issued guidance that if an audit review determines an ineligible recipient received CCDF assistance, such funds would be considered misspent and subject to disallowance. The Commission concludes that this guidance implies that federal child care benefits cannot be extended to individuals until the recipient has been determined to be eligible, including verifying citizenship and immigration status.

Comment: One commenter stated that there may be several situations in which the child may not have any of the documents listed in WD Letter 44-08, but may be a citizen or legal immigrant. These situations include children for whom an adult relative has temporary custody of a child in an abusive parental relationship; children in domestic violence situations; and children whose documents have been made unavailable due to fire or natural disaster.

Response: The Commission appreciates the comment and points out that authorizing child care for children in protective services is under the authority of Texas Department of Family and Protective Services' (DFPS) Child Protective Services (CPS) division. DFPS has confirmed that the citizenship or immigration status of children receiving protective services child care funded by CCDF is verified by CPS prior to authorizing child care services.

Regarding instances in which the child's documents may have been destroyed by fire or natural disaster, the Commission notes that the documents listed in WD Letter 44-08 are typically public records for which the parent can and should request replacements. The Commission does not anticipate that the request for the public document, particularly a birth certificate, would significantly delay the eligibility documentation process.

COMMENTS WERE RECEIVED FROM:

The Honorable Representative Eddie Rodriguez, State Representative, District 51

Andrew Rivas, Executive Director, Texas Catholic Conference

Blake Stanford, Texas Child and Adult Care Food Program Sponsors Association

Bruce Bower, Individual, and on behalf of Pax Christi Austin

Kate Lincoln-Goldfinch, American Gateways

Clint Smith, Gray Panthers of Texas

The rules are adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities, and the Texas Human Resources Code §44.002, regarding Administrative Rules.

The adopted rules will affect Texas Labor Code, Title 4, particularly Chapters 301 and 302, as well as Texas Government Code, Chapter 2308.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 2, 2009.

TRD-200902188
Reagan Miller
Deputy Division Director, Workforce Policy and Service Delivery Branch
Texas Workforce Commission
Effective date: June 22, 2009
Proposal publication date: December 12, 2008
For further information, please call: (512) 475-0829

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SUBCHAPTER E. REQUIREMENTS TO PROVIDE CHILD CARE

40 TAC §809.94

The Texas Workforce Commission (Commission) adopts the following new section, without changes, to Chapter 809, relating to Child Care Services, as published in the March 13, 2009, issue of the *Texas Register* (34 TexReg 1791):

Subchapter E. Requirements to Provide Child Care, §809.94

PART I. PURPOSE, BACKGROUND, AND AUTHORITY

PART II. EXPLANATION OF INDIVIDUAL PROVISIONS WITH COMMENTS AND RESPONSES

PART I. PURPOSE, BACKGROUND, AND AUTHORITY

The intent of the adopted changes to the Chapter 809 Child Care Services rules is to provide a mechanism by which the Commission and Local Workforce Development Boards (Boards) can ensure that child care providers receiving Commission child care funds are:

--meeting minimum health and safety standards as determined by the Texas Department of Family and Protective Services (DFPS); and

--providing the basic quality of care for children receiving Commission-funded child care.

The Commission rule changes are designed to balance two fundamental principles of the Child Care and Development Fund (CCDF):

--providing for the health and safety of children receiving subsidized child care; and

--ensuring that parents can choose from the full range of child care options to best suit their family needs.

Additionally, the Commission rules work in concert with the DFPS process for placing child care providers on corrective or adverse action. The Commission rules are based on DFPS regulatory remedies for child care providers that are found to be in noncompliance with health and safety standards and are designed to provide appropriate actions for Boards and parents, given the level of risk to children as determined by DFPS. The rules also balance parental choice and the health and safety of children with child care providers' due process for remedying regulatory deficiencies determined by DFPS.

Levels of Corrective and Adverse Action by DFPS

The Commission rules are predicated on the following three levels of actions that DFPS can take when a child care provider is found to be in noncompliance with state regulatory standards:

1. Evaluation Corrective Action

2. Probation Corrective Action

3. Adverse Action

According to the DFPS licensing rules at 40 TAC Chapter 745, DFPS may impose an evaluation corrective action (evaluation status) when a provider's deficiencies present a lower risk to children and, as long as the conditions imposed by the evaluation are followed, the provider does not need to cease operating to make the corrections. Evaluation status:

--involves a period of heightened monitoring;

--is imposed only after a plan for compliance has been developed and when a specific incident or pattern of deficiencies is not serious enough to require probation; and

--cannot be imposed for less than 30 days or for more than six months.

For providers placed on evaluation status, the Commission rules require Boards to ensure that parents with children enrolled, or parents wishing to enroll children, in Commission-funded child care with the provider are notified in writing of the provider's evaluation status with DFPS. A parent can choose to continue the enrollment with the provider if the parent signs an acknowledgment affirming that he or she has been notified of the provider's evaluation status and has chosen to continue the enrollment.

According to Chapter 745 of the DFPS rules, DFPS may impose a probation corrective action (probationary status) when a specific incident or a pattern of deficiencies can lead to adverse action. Probationary status:

--is appropriate where a risk to children may exist but when further action, such as closing the provider, is not necessary as long as the deficiencies are addressed through the corrective action plan; and

--cannot be imposed for less than 30 days or for more than one year.

Additionally, Chapter 745 of the DFPS rules requires providers placed on evaluation or probationary status to post the corrective action notice in a prominent place near each public entrance.

For providers placed on probationary status, the Commission rules require Boards to ensure that parents with children enrolled in Commission-funded child care with the provider are notified in writing of the provider's probationary status. A parent can choose to continue the enrollment with the provider if the parent signs an acknowledgment affirming that he or she has been notified of the provider's probationary status and has chosen to continue the enrollment. However, the Board must ensure that no new enrollments of children receiving Commission-funded child care are accepted with a provider in probationary status.

According to Chapter 745 of the DFPS rules, an adverse action is applied when DFPS attempts to close a provider. Adverse action is taken when DFPS determines that the provider has deficiencies that endanger the health and safety of children. DFPS adverse actions include notifying the provider of DFPS' intent to deny, revoke, or suspend the provider's permit. If an adverse action is taken, the provider has a right to request an administrative review and a hearing. If the adverse action is upheld, the provider must close. Chapter 745 of the DFPS rules also requires that when a provider receives notice from DFPS that it intends to take adverse action against the provider, the provider must post the notice of the adverse action in a prominent place near each public entrance. The provider must also notify each parent, guardian, or managing conservator of the children enrolled within five days of receiving the notice from DFPS.

The Commission rules do not allow reimbursements for Commission-funded child care to any provider against which DFPS is taking adverse action. Therefore, Boards must ensure that:

--no new referrals are made to the providers; and

--children currently enrolled in Commission-funded child care with such providers are transferred to another eligible provider.

Chapter 745 of the DFPS rules provides that if, during an inspection, DFPS licensing staff discovers conditions that pose a threat of immediate danger to the children, DFPS licensing staff can take immediate actions to remove the children and initiate an emergency suspension and closure order. When this happens, DFPS policies require the provider to notify parents to pick up their children within four hours or by the end of the day, whichever is longer. The operation is then closed for no more than 10 days. Further, DFPS must initiate an adverse action in the form of an intent to revoke no later than five days from the date of the emergency closure. Although the provider may request an administrative review of the emergency closure and adverse action, the provider cannot operate or care for children during the administrative review.

Because the emergency suspension and closure order requires all children at the facility to be removed from care, the Commission believes it is not necessary to address provider eligibility for reimbursement in Commission rules as the provider is not entitled to any reimbursement while children are not allowed in care. Furthermore, the emergency nature of the closure, the short time frame for parental notification, and the requirement for immediate removal of children make additional parental notification an unnecessary burden upon the Board.

However, issuance of an emergency suspension and closure order may not mean that a provider has ceased operating. Under Chapter 745 of DFPS rules, a provider may seek a court injunction to stop the emergency suspension and closure if the provider disagrees with the DFPS determination that the provider poses an immediate threat to children. The court may decide to uphold the decision to close the operation. On the other hand, the court may enjoin closure and allow the provider to continue operating pending the outcome of the administrative review of the adverse action.

Under DFPS rules, emergency closure actions are treated as adverse actions. Consistent with this approach, the Commission rules require Boards to treat a provider that, by a court order, is continuing operations pending the outcome of the administrative review, in accordance with the procedures for adverse actions.

Parent Choice

CCDF regulations at 45 C.F.R. §98.30 require states to allow parents to choose from a variety of child care categories including care in child care centers, group homes, and family homes, and care in the child's home. States cannot promulgate rules that significantly restrict parental choice in categories of care or that have the effect of excluding categories of care. Although the rules may affect a parent's choice of a particular individual provider under certain circumstances (specifically, providers placed on probationary status or adverse action), the rules neither restrict parents' choice of a particular provider category nor have the effect of excluding a substantial number of providers in any category.

According to DFPS data, the number of licensed and registered child care providers in State Fiscal Year 2008 (SFY'08) (September 1, 2007, through August 31, 2008) totaled 19,995. Also during SYF'08, 320 child care providers were placed on corrective or adverse action. Of those, 211 were placed on corrective action (113 on evaluation status and 98 on probationary status), and 109 were placed on adverse action. Therefore, the providers affected by these rules represent approximately 1.6 percent of all providers. DFPS data also shows that approximately 2.3 percent of licensed child care centers, 1.3 percent of licensed homes, and 0.8 percent of registered homes were placed on some type of corrective or adverse action.

The rules do not limit parent choice of the full range of provider categories in any specific local workforce development area (workforce area). Harris County had 86 providers on corrective or adverse action, followed by Bexar County with 22 providers. Only 5 other counties in Texas had more than 10 providers on corrective or adverse action. These providers represent less than 1 percent of the providers in a particular workforce area. Finally, of the 320 providers on corrective or adverse action during SFY'08, only 184 served children receiving Commission-funded child care. During that same period, 9,023 regulated providers cared for children receiving Commission-funded child care. Therefore, only 2 percent of regulated providers serving children in Commission-funded child care were placed on any type of corrective or adverse action.

Based on this data, the Commission concludes that these rules will not significantly limit parent choice of any provider category. Additionally, the rules allow a parent to enroll a child with a provider that is on evaluation status and allow a parent with a child currently enrolled with a provider on evaluation status to continue enrollment (provided the parent signs a statement acknowledging that the parent is aware of the provider's status with DFPS).

However, providers against whom DFPS is taking adverse action have been found by DFPS to have deficiencies that pose a risk to children. The Commission believes it is necessary to ensure the health and safety of children receiving publically subsidized child care, therefore the rules do not allow parents of children enrolled in Commission-funded child care the choice of a provider on adverse action.

Administrative Review Process through DFPS

The Commission emphasizes that Boards must allow a provider on corrective or adverse action to pursue DFPS' administrative review prior to the Board taking action to notify the parents, close enrollment, or transfer children. DFPS rules, Chapter 745, give providers 15 days from the initial notification of corrective or adverse action to request an administrative review. However, providers may request a waiver of an administrative review within that 15-day period. DFPS provides official notice to the provider following the administrative review or after receiving the request from the provider to waive the administrative review.

To assist in the implementation of these rules, DFPS has agreed to provide the Agency with an official notification when providers are placed on corrective or adverse action. Upon receiving notification from DFPS, the Agency will notify the affected Board. The Commission will provide further guidance and procedures to Boards through the issuance of a Workforce Development (WD) Letter. The rule language specifies that Board actions are taken only after receiving notification from the Agency of the provider's official status with DFPS.

The Commission also emphasizes the importance of allowing the DFPS administrative review to be completed prior to notifying the parents, closing enrollment, or transferring children to another provider. This allows providers to address any due process issues through DFPS. The administrative review is conducted under DFPS standard rules and procedures as set out in Chapter 745. The decision to place the provider on corrective or adverse action rests solely with DFPS and includes the DFPS' administrative review process. Therefore, the provider cannot appeal this decision to the Board. Further, the provider has no appeal

rights to the Agency under Chapter 823, the Commission's Integrated Complaints, Hearings, and Appeals rules.

PART II. EXPLANATION OF INDIVIDUAL PROVISIONS WITH COMMENTS AND RESPONSES

SUBCHAPTER E. REQUIREMENTS TO PROVIDE CHILD CARE

The Commission adopts the following new section to Subchapter E:

§809.94. Providers Placed on Corrective or Adverse Action by the Texas Department of Family and Protective Services.

New §809.94 sets forth actions Boards must take when a provider is placed on corrective or adverse action by DFPS.

Section 809.94(a) describes Board requirements regarding providers placed on evaluation corrective action (evaluation status).

Section 809.94(a)(1) requires Boards to ensure that parents with children currently enrolled in Commission-funded child care with the provider are notified in writing of the provider's evaluation status. The Board must ensure that parents are notified no later than five business days from receipt of the Agency's notification of the DFPS decision to place the provider on evaluation status.

Section 809.94(a)(2) requires Boards to ensure that parents choosing to enroll a child in Commission-funded child care with a provider on evaluation status are notified of the provider's status with DFPS prior to enrolling the child.

Section 809.94(b) describes Board requirements regarding providers placed on probation corrective action (probationary status).

Section 809.94(b)(1) requires Boards to ensure that parents with children currently enrolled in Commission-funded child care with the provider are notified in writing of the provider's probationary status. These requirements mirror those in §800.94(a)(1) for children enrolled with a provider on evaluation status. The Board must ensure that parents are notified no later than five business days from receipt of the Agency's notification of DFPS' decision to place the provider on probationary status. If a parent decides to continue enrollment with a provider on corrective action (i.e., evaluation or probationary status), the parent must sign a written acknowledgment that he or she has been notified of the provider's status.

The Commission allows parents with children currently enrolled in Commission-funded child care with a provider on evaluation or probationary status to continue this enrollment in order to preserve parent choice and avoid any disruption of child care. The Commission recognizes that the current placement may best meet the needs of the working parent--requiring parents to transfer to another provider may place an undue burden on the parents and jeopardize their work arrangements.

Section 809.94(b)(2) requires that Boards must ensure that no new referrals are made to providers on probationary status. DFPS' decision to place a provider on probationary status involves findings that present a higher risk to children, thus it is essential that no new enrollments of children receiving Commission-funded child care occur until the provider corrects the deficiencies and is removed from probationary status by DFPS. The intent of this requirement is to ensure that the provider is aware of the importance of correcting any deficiencies as well as to ensure that children are initially placed with providers that meet minimum health and safety requirements.

Section 809.94(c) allows parent choice when a parent wants a child to be enrolled or continued to be enrolled with a provider on DFPS corrective action. A parent receiving the notification of the provider's status with DFPS, but who chooses to continue enrollment with the provider must sign an acknowledgment indicating that he or she is aware of the provider's status with DFPS, but has chosen to continue with the enrollment. The parent must return the acknowledgment to the Board's child care contractor within 10 days of receiving the notification.

The Commission believes that a parent should be informed and acknowledge in a signed document that enrollment with the provider is the parent's choice. Although this will not necessarily prevent future litigation by the parent, requiring a parent to affirmatively acknowledge his or her decision is consistent with the principle of parental choice and establishes informed consent should something happen to the child while in the provider's care.

Section 809.94(d) prohibits providers on any corrective action from receiving enhanced reimbursement rates under §809.20. Specifically, providers who are Texas Rising Star (TRS) certified, participating in Texas Early Education Model (TEEM), or Texas School Ready!™ certified are prohibited from receiving enhanced reimbursement rates while on DFPS evaluation or probationary status. The providers will remain eligible to receive the Board's regular reimbursement rate, but will not be eligible for the enhanced rate. It is the Commission's intent that providers receiving enhanced reimbursement rates are being compensated for attaining higher quality of early care and education. Therefore, if DFPS has placed a provider on corrective or adverse action, then the provider is not offering a higher quality of early care and education.

Section 809.94(e) sets forth Board requirements regarding providers against whom DFPS is taking adverse action.

Section 809.94(e)(1) requires that Boards notify parents with children enrolled in Commission-funded child care no later than two business days after receiving notification from the Agency that DFPS is taking adverse action against the provider. The Commission includes a maximum two-day notification requirement to emphasize the importance of timely notification when a provider is on adverse action. Because adverse action is taken when DFPS determines that conditions at the provider pose a risk to the health and safety of the children, it is important to notify parents of children receiving Commission-funded child care as quickly as possible. In order to speed the notification process, the Commission also notes that the notification does not have to be in writing, but may be a notification by phone or other means. The Board may provide written notification as long as the notification is provided to the parent no later than two days from receiving notification from the Agency.

Section 809.94(e)(2) requires Boards to ensure that children enrolled in Commission-funded child care with the provider are removed from care at that provider no later than five business days after receiving notification from the Agency that DFPS is taking adverse action against the provider. Although it is important to stress the timely nature of ensuring parental notification, it is also important to provide the parent with sufficient time and opportunity to locate and choose another eligible provider that meets the child care needs of the parent.

Section 809.94(e)(3) requires Boards to ensure that no new referrals for Commission-funded child care are made to the provider while DFPS is taking adverse action.

Finally, §809.94(f) sets forth the provisions applicable to a provider for which DFPS has determined that the provider poses an immediate risk to the health or safety of children and cannot operate pending appeal of the adverse action, but for which there is a valid court order that overturns DFPS' determination and allows the provider to operate pending administrative review or appeal. Commission rules state that in this situation, Boards must take action consistent with the provisions of §809.94(e). The Board must treat this situation in the same manner as a provider against whom DFPS intends to take adverse action. Specifically, the Board must notify parents no later than two business days after receiving notification from the Agency that the provider is on adverse action with DFPS and ensure that enrolled children in Commission-funded child care are removed from that provider's care no later than five business days after receiving notification from the Agency that the provider is on adverse action with DFPS.

Comment: One commenter representing Board and Board child care contractor staff agreed with the rule changes and thanked the Commission for making the changes. The commenter stated that the changes were needed and were the right direction to go.

Response: The Commission appreciates the comment and thanks the Boards for providing input during the rulemaking process.

COMMENTS WERE RECEIVED FROM:

Joyce Sneed, on behalf of the Concho Valley Workforce Development Board and the Board's child care contractor.

The rule is adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities, and the Texas Human Resources Code §44.002, regarding Administrative Rules.

The adopted rule affects Texas Labor Code, Title 4, particularly Chapters 301 and 302, as well as Texas Government Code, Chapter 2308.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 2, 2009.

TRD-200902189

Reagan Miller

Deputy Division Director, Workforce Policy and Service Delivery Branch

Texas Workforce Commission

Effective date: June 22, 2009

Proposal publication date: March 13, 2009

For further information, please call: (512) 475-0829

REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

Adopted Rule Reviews

Texas Medical Board

Title 22, Part 9

The Texas Medical Board (Board) adopts the review of Chapter 174, Telemedicine, §§174.1 - 174.6, pursuant to the Texas Government Code, §2001.039. The proposed rule review was published in the May 1, 2009, issue of the *Texas Register* (34 TexReg 2683).

No comments were received regarding adoption of the review.

The agency's reason for adopting the rules contained in this chapter continues to exist.

This concludes the review of Chapter 174, Telemedicine.

TRD-200902229
Mari Robinson, J.D.
Interim Executive Director
Texas Medical Board
Filed: June 4, 2009

♦ ♦ ♦

TABLES & GRAPHICS

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure: 4 TAC §45.2(a)

Multiple species diseases

Akabane - Akabane virus

Anthrax**- Bacillus anthracis

Aujeszky's disease - Pseudorabies virus, herpesvirus suis

Leishmaniasis** - Leishmania infantum and L donavani

Foot and mouth disease - Aphthovirus, types A,O,C, SAT, Asia

Heartwater - Cowdria ruminantium

African Trypanosomosis (Nagana) - Trypanosoma brucei, T. vivax,

T. brucei

Rinderpest - Morbillivirus

Rift Valley fever - Bunya virus

Vesicular stomatitis - Rhabdovirus; 2 serotypes; New Jersey and Indiana

Screwworm - Cochliomyia hominivorax

Cattle diseases (including Exotic Bovidae)

Bovine babesiosis - *B. bovis, B. divergens*, Babesia microti

Bovine brucellosis - Brucella abortus

Bovine ephemeral fever – Rhabdovirus

Bovine trichomonosis – trichomoniasis****

Bovine tuberculosis - Mycobacterium bovis

East coast fever (Theileriosis) - Theileria parva

Malignant catarrhal fever (wildebeest associated) - Alcelaphine

herpesvirus (AHV 1)

Contagious bovine pleuropneumonia - Mycoplasma mycoides

Lumpy skin disease - Neethling poxvirus

Bovine spongiform encephalopathy

Scabies - Sarcoptes scabiei, Psoroptes bovis, Chorioptes bovis

Cervidae

Brucellosis - Brucella abortus, Brucella suis (biotype 4)

Chronic Wasting Disease

Tuberculosis - Mycobacterium bovis

Sheep and goat diseases

Caprine and ovine brucellosis (not B. ovis infection) – Brucella melitensis

Contagious caprine pleuropneumonia - Mycoplasma capri (biotype 78)

Louping ill - Flavovirus

Nairobi sheep disease - Bunyaviridae

Peste des petits ruminants - Morbillivirus, Paramyxoviridae family

Sheep pox and goat pox - Capripoxvirus

Scrapie

Scabies - Sarcoptes scabiei

Equine diseases

African horse sickness - Orbivirus

Contagious equine metritis - Tayorella equigenitalis

Dourine - Trypanosoma equiperdum

Epizootic lymphangitis - Histoplasma farciminosum

Equine encephalomyelitis (Eastern and Western)** - Alphavirus

Equine infectious anemia - Lentivirus

Equine morbillivirus pneumonia - Morbillivirus

Equine piroplasmosis - Babesia equi, B. caballi

Glanders - Pseudomonas mallei

Japanese encephalitis - Flavovirus

Surra - Trypanosoma evansi

Venezuelan equine encephalomyelitis** - Alphavirus; Togaviridae family

Equine Viral Arteritis (EVA)***

Equine Herpes Virus-1 (EHV-1)

Swine diseases

African swine fever - Poxvirus

Classical swine fever (hog cholera) - Togovirus

Pseudorabies - Herpesvirus suis

Porcine brucellosis - Brucella suis

Swine vesicular disease - Picornavirus

Vesicular Exanthema - Calicivirus

Poultry diseases

Avian influenza - Orthomyxoviruse

Avian infectious laryngotracheitis - Orthomyxovirus, herpesvirus

Avian tuberculosis - Mycobacterium avium serovars 1,2

Duck virus hepatitis - Picornavirus

Fowl typhoid - Salmonella gallinarum

Highly pathogenic avian influenza (fowl plague) – Orthomyxovirus (type H5 or H7)

Infectious encephalomyelitis - Arbovirus

Ornithosis (psitticosis) - Chlamydia psittaci

Pullorum disease - Salmonella pullorum

Newcastle disease (VVND) - Paramyxovirus-1 (PMV-1)

Paramyxovirus infections (other than Newcastle disease) - PMV-2 to PMV-9

Rabbit diseases

Myxomatosis - Myxomatosis virus

Viral haemorrhagic disease of rabbits - Calciviral disease

**These diseases are also reportable to the Department of State Health Services (DSHS)

***This disease has reporting standards in Chapter 49, §49.4 of this title.

****Results of tests for this disease shall be reported within 48 hours of completion of the tests.

Figure: 25 TAC §139.6(a)(1)

TOLL-FREE TELEPHONE NUMBER

1-888-973-0022

You have the right to access certain information concerning this abortion facility by using the toll-free telephone number listed above. If you make a call to the number, your identity will remain anonymous.

The toll-free telephone line can provide you with the following information:

- whether this abortion facility is licensed by the Department of State Health Services;
- the date of the last inspection of this facility by the Department of State Health Services and any violations of law or rules discovered during that inspection that may pose a health risk to you;
- any relevant fine, penalty, or judgment rendered against this facility or a doctor who provides services at this facility.

Figure: 25 TAC §139.6(a)(2)

LÍNEA DE INFORMACIÓN GRATUITA

1-888-973-0022

Usted tiene el derecho de obtener cierta información concerniente a este centro de aborto usando la línea de información gratuita que aparece arriba. Si usted llama a este número, su identidad permanecerá anónima.

La línea de información gratuita puede ofrecerle la siguiente información:

- Si este centro de aborto tiene licencia del Departamento Estatal de Servicios de Salud de Texas.

- La fecha de la última inspección de este centro por el Departamento Estatal de Servicios de Salud de Texas, y cualquier infracción de la ley o de las reglas descubierta durante esa inspección, que pudiera poner en peligro su salud.

- Cualquier multa, pena o sentencia impuesta en contra de este centro o de algún doctor que preste servicios en ese lugar.

IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Office of the Attorney General

Texas Health and Safety and Texas Water Code Settlement Notice

Notice is hereby given by the State of Texas of the following proposed resolution of an environmental enforcement lawsuit under the Texas Health and Safety Code, and Texas Water Code. Before the State may settle a judicial enforcement action under the Water Code, the State shall permit the public to comment in writing on the proposed judgment. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreed judgment if the comments disclose facts or considerations that indicate that the consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the Code.

Case Title and Court: *Harris County, Texas and the State of Texas by and through the Texas Commission on Environmental Quality v. KMCO, Inc.,* Cause No. 2008-16597; in the 215th Judicial District Court, Harris County, Texas.

Nature of Defendant's Operations: Defendant owns and operates an industrial chemical distillation and manufacturing facility in Crosby, Texas. Defendant's operations discharged wastewater exceeding its permit levels for ammonia and other constituents. Defendant also released noxious odors in such concentration as to impact surrounding residents.

Proposed Agreed Judgment: The Agreed Final Judgment orders the Defendant to pay a cash penalty and fund a supplemental environmental project, totaling $175,000. Defendant agrees to pay each Plaintiff $50,000 in cash penalty, with the remaining $75,000 deferred upon completion of the supplemental environmental project. Defendant will pay the State $17,500 in attorneys fees plus all court costs.

For a complete description of the proposed settlement, the complete proposed Agreed Final Judgment should be reviewed. Requests for copies of the judgment, and written comments on the proposed settlement, should be directed to Anthony W. Benedict, Assistant Attorney General, Environmental Protection and Administrative Law Division, Office of the Texas Attorney General, P.O. Box 12548, Austin, Texas 78711-2548, (512) 463-2012, facsimile (512) 320-0911. Written comments must be received within 30 days of publication of this notice to be considered.

For information regarding this publication, contact Zindia Thomas, Agency Liaison, at (512) 936-9901.

TRD-200902292
Stacey Napier
Deputy Attorney General
Office of the Attorney General
Filed: June 8, 2009

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Coastal Coordination Council

Notice and Opportunity to Comment on Requests for Consistency Agreement/Concurrence Under the Texas Coastal Management Program

On January 10, 1997, the State of Texas received federal approval of the Coastal Management Program (CMP) (62 Federal Register pp. 1439-1440). Under federal law, federal agency activities and actions affecting the Texas coastal zone must be consistent with the CMP goals and policies identified in 31 TAC Chapter 501. Requests for federal consistency review were deemed administratively complete for the following project(s) during the period of May 29, 2009, through June 4, 2009. As required by federal law, the public is given an opportunity to comment on the consistency of proposed activities in the coastal zone undertaken or authorized by federal agencies. Pursuant to 31 TAC §§506.25, 506.32, and 506.41, the public comment period for this activity extends 30 days from the date published on the Coastal Coordination Council web site. The notice was published on the web site on June 10, 2009. The public comment period for this project will close at 5:00 p.m. on July 10, 2009.

FEDERAL AGENCY ACTIONS:

Applicant: Orange County Navigation and Port District; Location: The project site is located along the Sabine River (Mile Marker 27), at 2599 South Childers Drive, in Orange County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Orange, Texas. Approximate UTM Coordinates in NAD 83 (meters): Zone 15; Easting: 430897; Northing: 3326600. Project Description: The applicant proposes to construct a marine terminal. The construction associated with the proposed terminal will consist of three 60- by 12-foot access ramps each with a 20- by 30-foot pile supported metal dock, and one 295- by 32-foot access ramp with two 20-by 30-foot pile supported metal docks. Each access ramp will be lined with a sheet pile bulkhead. The construction associated with the access ramps will require the placement of fill material into 0.21 acre of open water. CCC Project No.: 09-0170-F1. Type of Application: U.S.A.C.E. permit application #SWG-2008-01024 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: Bluewater Investments; Location: The project is located a 55-acre tract of land adjacent to the Gulf Intracoastal Waterway (GIWW), near Matagorda, in Matagorda County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Matagorda, Texas. Approximate UTM Coordinates in 83 (meters): Zone 15; Easting: 217423; Northing: 3180104. Project Description: The applicant proposes construct a 150-lot residential subdivision with inland canals and related infrastructure. Construction activities include: inland and open water mechanical excavation, removal of existing bulkhead, installation of new bulkhead, fill and excavation of jurisdictional wetlands, and freshwater and estuarine wetland creation. A community walkover in a nature preserve area, 3 outfalls, and 12 piers with boathouses are also proposed. Approximately 9.62 acres of inland canals will be excavated with a total of approximately 92,626 cubic yards of material to be removed. The material will be used to raise the elevation of the project site. Further excavation of an existing barge canal is proposed with 11,551 cubic yards of material

to be removed. CCC Project No.: 09-0174-F1. Type of Application: U.S.A.C.E. permit application #SWG-2007-01668 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project may be conducted by the Texas Commission on Environmental Quality under §401 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: SandRidge Offshore, LLC; Location: The project is located in Galveston Bay, approximately 16 miles northeast of Texas City, in Chambers County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Umbrella Point, Texas. Approximate Coordinates in NAD 83: Lat: 29.6278, Long: -94.8357. Project Description: The applicant proposes to relocate and install two concrete barges, one being relocated from an existing location in Umbrella Point field, and the second brought from Sabine Lake. For each location, silt will be removed and filled with 673 cubic yards of limestone to secure a pad for each barge. CCC Project No.: 09-0177-F1. Type of Application: U.S.A.C.E. permit application #SWG-2001-01919 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project may be conducted by the Railroad Commission of Texas under §401 of the Clean Water Act (33 U.S.C.A. §1344).

Pursuant to §306(d)(14) of the Coastal Zone Management Act of 1972 (16 U.S.C.A. §§1451-1464), as amended, interested parties are invited to submit comments on whether a proposed action is or is not consistent with the Texas Coastal Management Program goals and policies and whether the action should be referred to the Coastal Coordination Council for review.

Further information on the applications listed above, including a copy the consistency certifications for inspection, may be obtained from Ms. Tammy Brooks, Consistency Review Coordinator, Coastal Coordination Council, P.O. Box 12873, Austin, Texas 78711-2873, or tammy.brooks@glo.state.tx.us. Comments should be sent to Ms. Brooks at the above address or by fax at (512) 475-0680.

TRD-200902322
Larry L. Laine
Chief Clerk/Deputy Land Commissioner, General Land Office
Coastal Coordination Council
Filed: June 10, 2009

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Comptroller of Public Accounts

Notice of Contract Amendment

The Comptroller of Public Accounts (Comptroller) announces the amendment of the following contract award:

The notice of request for proposals was published in the April 2, 2004, issue of the *Texas Register* (29 TexReg 3515) (RFP #167k). The Notice of Award was published in the September 17, 2004, issue of the *Texas Register* (29 TexReg 9030).

The contractor provides investment management services to the Comptroller and the Texas Prepaid Higher Education Tuition Board.

The contract was awarded to Brandywine Global Investment Management LLC (formerly known as Brandywine Asset Management, LLC), 2929 Arch Street, Suite 800, Philadelphia, PA 19104. The total amount of the contract is based on a percentage of assets under management. The original term of the contract was August 22, 2004 through August 31, 2009. The amendment extends the term of the contract through August 31, 2010.

TRD-200902294
William Clay Harris
Assistant General Counsel, Contracts
Comptroller of Public Accounts
Filed: June 9, 2009

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Notice of Contract Amendment

The Comptroller of Public Accounts (Comptroller) announces the amendment of the following contract award:

The notice of request for proposals was published in the April 2, 2004, issue of the *Texas Register* (29 TexReg 3515) (RFP #167L). The Notice of Award was published in the July 30, 2004, issue of the *Texas Register* (29 TexReg 7517).

The contractor provides investment management services to the Comptroller and the Texas Prepaid Higher Education Tuition Board.

The contract was awarded to Fountain Capital Management LLC, 10801 Mastin Blvd., Suite 220, Overland Park, Kansas 66201. The total amount of the contract is based on a percentage of assets under management. The original term of the contract was July 12, 2004 through August 31, 2009. The amendment extends the term of the contract through August 31, 2010.

TRD-200902295
William Clay Harris
Assistant General Counsel, Contracts
Comptroller of Public Accounts
Filed: June 9, 2009

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Notice of Contract Amendment

The Comptroller of Public Accounts (Comptroller) announces the amendment of the following contract award:

The notice of request for proposals was published in the May 6, 2005, issue of the *Texas Register* (30 TexReg 2784) (RFP #172e). The Notice of Award was published in the March 17, 2006, issue of the *Texas Register* (31 TexReg 2291).

The contractor provides institutional commission recapture brokerage services to the Comptroller and the Texas Prepaid Higher Education Tuition Board (Board).

The contract was awarded to Abel Noser Corporation, One Battery Park Plaza, Sixth Floor, New York, New York 10004. The total amount of the contract is based on a percentage of commissions generated, recaptured, and reimbursed back to the Comptroller and the Board. The original term of the contract was January 26, 2006 through December 31, 2009. The amendment extends the term of the contract through August 31, 2010.

TRD-200902296
William Clay Harris
Assistant General Counsel, Contracts
Comptroller of Public Accounts
Filed: June 9, 2009

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §303.003, 303.005, and 303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 06/15/09 - 06/21/09 is 18% for Consumer[1]/Agricultural/Commercial[2] credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 06/15/09 - 06/21/09 is 18% for Commercial over $250,000.

[1]Credit for personal, family or household use.

[2]Credit for business, commercial, investment, or other similar purpose.

TRD-200902289
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: June 8, 2009

♦ ♦ ♦

Texas Council for Developmental Disabilities

Requests for Ideas: Developing Meaningful Relationships Project

The Texas Council for Developmental Disabilities (TCDD) is established by and funded under state and federal law and is responsible to promote the development of supports and services necessary for individuals with developmental disabilities to be fully included in their communities. The TCDD is responsible for developing a State Plan and approving grant projects to carry out objectives in the State Plan.

The TCDD announces a Request for Ideas (RFI) to obtain suggestions for future grants, projects, or activities that will support individuals with developmental disabilities to develop meaningful, healthy, personal relationships with other people.

An RFI is a process to solicit creative ideas for possible future projects. This method of gathering information is a tool to explore innovative ways to address identified needs of people with developmental disabilities for consideration by TCDD. An RFI is not a solicitation for proposals with funding attached. It is a request for ideas and suggestions only. Ideas must be innovative and respond to an identified barrier or issue pertinent to the lives of individuals with developmental disabilities living in Texas.

Ideas submitted under this RFI must describe a specific project that addresses an identified need. All submitted project ideas must respect and promote self-determination and individual choice in the lives of people with disabilities. TCDD will not consider or incorporate in potential future RFPs or activities Project Ideas that propose using funding for ongoing, administrative, or operational expenses of existing programs.

Ideas meeting the specified criteria will be reviewed by TCDD. TCDD may approve issuing a Request for Proposals (RFP) for a project or project(s) similar to ideas submitted from one or a number of submittals under this RFI. If released as an RFP, organizations that submitted ideas and other interested parties are eligible to submit a complete proposal to TCDD for funding. Responding to an RFI is a way to propose a project idea that may be considered for future funding, but is not a way to quickly fund a project.

For questions about this Request for Ideas, contact Joanna Cordry, Planning Coordinator, at (512) 437-5410 (voice) or e-mail Joanna.Cordry@tcdd.state.tx.us.

To obtain the complete RFI packet, download material directly from the TCDD Web site at www.txddc.state.tx.us or request a copy in writing by U.S. mail, fax, or e-mail from Barbara Booker at the Texas Council for Developmental Disabilities, 6201 E. Oltorf Street, Suite 600, Austin, Texas 78741-7509; fax number (512) 437-5434; e-mail address Barbara.Booker@tcdd.state.tx.us. Packets must be requested in writing unless downloaded from the Internet.

Background:

TCDD seeks ideas for a project that would support individuals in forming the kinds of relationships that they desire. Proposals may address the development of one or many different types of close, meaningful relationships, including friendships, dating relationships, marriages, and/or relationships with providers. Proposals should not be for social skills training alone and should not be primarily for abuse-neglect prevention.

Proposal Components and Terms:

Specific proposal components and terms may be found in the RFI Application Packet.

Eligibility:

Individuals and organizations may submit ideas under this RFI.

Deadlines and Submission Process:

One electronic copy must be submitted. Electronic copies should be provided on a CD in Word format or submitted electronically to Barbara.Booker@tcdd.state.tx.us.

An additional hard copy may be submitted. Hard copies may be delivered by hand or mailed to TCDD's physical office at 6201 East Oltorf, Suite 600, Austin, Texas 78741-7509. Responses should be directed to the attention of Barbara Booker.

All responses must be received by TCDD not later than 4:00 p.m., Central Daylight Time, Friday, August 14, 2009.

Responses may not be accepted after the due date.

TRD-200902231
Roger Webb
Executive Director
Texas Council for Developmental Disabilities
Filed: June 4, 2009

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Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (the Code), §7.075. Section 7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. Section 7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **July 20, 2009.** Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on July 20, 2009.** Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that comments on the AOs shall be submitted to the commission in **writing.**

(1) COMPANY: Brian Kwon dba 7 Station; DOCKET NUMBER: 2009-0378-PST-E; IDENTIFIER: RN100881564; LOCATION: Houston, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 Texas Administrative Code (TAC) §334.7(d)(3), by failing to notify the agency of any change or additional information regarding underground storage tanks (USTs); 30 TAC §334.50(b)(1)(A) and the Code, §26.3475(c)(1), by failing to monitor USTs for releases; 30 TAC §334.50(b)(2) and the Code, §26.3475(a), by failing to provide proper release detection for the piping associated with the USTs; 30 TAC §334.50(b)(2)(A)(i)(III) and the Code, §26.3475(a), by failing to test the line leak detectors at least once per year for performance and operational reliability; 30 TAC §334.50(d)(1)(B)(ii) and the Code, §26.3475(c)(1), by failing to conduct reconciliation of detailed inventory control records; 30 TAC §334.50(d)(1)(B)(iii)(I) and the Code, §26.3475(c)(1), by failing to record inventory volume measurement for regulated substance inputs, withdrawals, and the amount still remaining in the tank each operating day; 30 TAC §334.48(c), by failing to conduct effective manual or automatic inventory control procedures for all USTs; 30 TAC §115.244(1) and (3) and Texas Health and Safety Code (THSC), §382.085(b), by failing to conduct daily and monthly inspections of the Stage II vapor recovery system (VRS); 30 TAC §115.248(1) and THSC, §382.085(b), by failing to ensure that at least one station representative received training in the operation and maintenance of the Stage II VRS and each current employee received in-house Stage II vapor recovery training; 30 TAC §115.246(1) and (3) and THSC, §382.085(b), by failing to maintain all required Stage II records at the station and make them immediately available for review upon request by agency personnel; 30 TAC §115.242(3)(K) and THSC, §382.085(b), by failing to maintain the Stage II VRS in proper operating condition as specified by the manufacturer and/or any applicable California Air Resource Board Executive Order, and free of defects that would impair the effectiveness of the system; and 30 TAC §115.245(2) and THSC, §382.085(b), by failing to verify proper operation of the Stage II equipment; PENALTY: $11,178; ENFORCEMENT COORDINATOR: Rajesh Acharya, (512) 239-0577; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(2) COMPANY: 1404 Blaketree, L.P.; DOCKET NUMBER: 2009-0457-PWS-E; IDENTIFIER: RN105362487; LOCATION: Montgomery County; TYPE OF FACILITY: golf club with public water supply (PWS); RULE VIOLATED: 30 TAC §290.109(c)(2)(A)(i) and §290.122(c)(2)(B) and THSC, §341.033(d), by failing to collect routine coliform samples; PENALTY: $4,578; ENFORCEMENT COORDINATOR: Yuliya Dunaway, (210) 490-3096; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(3) COMPANY: Bell County Water Control & Improvement District Number 2; DOCKET NUMBER: 2009-0554-MWD-E; IDENTIFIER: RN101610491; LOCATION: Bell County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1) and (5), Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0011090001, Permit Conditions Number 2.d. and Operational Requirements Number 1, and the Code, §26.121(a), by failing to prevent the unauthorized discharge of sludge and floating solids; PENALTY: $2,750; ENFORCEMENT COORDINATOR: Tom Jecha, (512) 239-2576; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(4) COMPANY: City of Bogata; DOCKET NUMBER: 2009-0494-PWS-E; IDENTIFIER: RN101180263; LOCATION: Bogata, Red River County; TYPE OF FACILITY: PWS; RULE VIOLATED: 30 TAC §290.42(1), by failing to compile and maintain a thorough plant operations manual for operator review and reference; 30 TAC §290.43(e), by failing to enclose all potable water storage tanks with an intruder-resistant fence with lockable gates; 30 TAC §290.46(m)(6), by failing to maintain pumps, motors, valves, and other mechanical devices in good working condition; 30 TAC §290.121(a) and (b), by failing to compile and maintain on file an up-to-date chemical and microbiological monitoring plan; 30 TAC §290.45(b)(1)(D)(iv) and THSC, §341.0315(c), by failing to provide an elevated storage capacity of 100 gallons per connection or a pressure tank capacity of 20 gallons per connection; and 30 TAC §290.46(u), by failing to plug an abandoned PWS well with cement or test the well every five years or as required by the executive director to prove that they are in a non-deteriorated condition; PENALTY: $1,050; ENFORCEMENT COORDINATOR: Andrea Linson-Mgbeoduru, (512) 239-1482; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(5) COMPANY: CAL-MOD ENTERPRISES, LLC dba Hempstead Truck Stop; DOCKET NUMBER: 2009-0455-PST-E; IDENTIFIER: RN101787638; LOCATION: Houston, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.245(2) and THSC, §382.085(b), by failing to verify proper operation of the Stage II equipment; and 30 TAC §115.242(3) and THSC, §382.085(b), by failing to maintain the Stage II VRS in proper operating condition; PENALTY: $6,790; ENFORCEMENT COORDINATOR: Rajesh Acharya, (512) 239-0577; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(6) COMPANY: Copperas Cove Mobile Home Community, L.L.C. dba Cedar Grove Mobile Home Park; DOCKET NUMBER: 2008-0835-PWS-E; IDENTIFIER: RN101186724; LOCATION: Copperas Cove, Coryell County; TYPE OF FACILITY: PWS; RULE VIOLATED: 30 TAC §290.39(m), by failing to provide written notification to the commission of the reactivation of an existing PWS system; PENALTY: $90; ENFORCEMENT COORDINATOR: Stephen Thompson, (512) 239-2558; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(7) COMPANY: Delicias Restaurant Store LLC; DOCKET NUMBER: 2009-0769-PST-E; IDENTIFIER: RN101212389; LOCATION: Encino, Brooks County; TYPE OF FACILITY: restaurant/store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(a)(1)(A), by failing to provide release detection; 30 TAC §334.49(a)(1), by failing to provide corrosion protection; 30 TAC §334.50(d)(1)(B), by failing to implement inventory control methods; 30 TAC §334.8(c)(5)(A)(i), by failing to possess a valid TCEQ delivery certificate prior to receiving fuel; and 30 TAC §334.8(c), by failing to submit initial/renewal UST registration and self-certification form; PENALTY: $7,700; ENFORCEMENT COORDINATOR: Keith Frank, (512) 239-1203; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

(8) COMPANY: Denny Oil Company dba North Street Texaco; DOCKET NUMBER: 2008-1276-PST-E; IDENTIFIER:

RN102381845; LOCATION: Nacogdoches, Nacogdoches County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.51(a)(6) and the Code, §26.3475(c)(2), by failing to assure that spill and overfill prevention equipment are maintained in good operating condition; PENALTY: $2,000; ENFORCEMENT COORDINATOR: Tom Greimel, (512) 239-5690; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(9) COMPANY: Denny Transport, L.L.C.; DOCKET NUMBER: 2009-0454-PST-E; IDENTIFIER: RN102381845; LOCATION: Nacogdoches, Nacogdoches County; TYPE OF FACILITY: fuel distributor; RULE VIOLATED: 30 TAC §334.48(a) and §334.51(a) and the Code, §26.121(a) and §26.3475(c)(2), by failing to prevent a spill from a UST system resulting in an unauthorized discharge of regulated substances; PENALTY: $3,750; ENFORCEMENT COORDINATOR: Tom Greimel, (512) 239-5690; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(10) COMPANY: Dumas Used Cars, Inc.; DOCKET NUMBER: 2008-1549-PST-E; IDENTIFIER: RN101780740; LOCATION: Port Lavaca, Calhoun County; TYPE OF FACILITY: used car sales; RULE VIOLATED: 30 TAC §334.47(a)(2), by failing to permanently remove from service, no later than 60 days after the prescribed implementation date, three USTs; PENALTY: $5,250; ENFORCEMENT COORDINATOR: Danielle Porras, (512) 239-2602; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

(11) COMPANY: Honeywell International, Inc.; DOCKET NUMBER: 2009-0264-AIR-E; IDENTIFIER: RN100217405; LOCATION: Orange, Orange County; TYPE OF FACILITY: synthetic chemical production plant; RULE VIOLATED: 30 TAC §116.110(a)(1) and THSC, §382.0518(a) and §382.085(b), by failing to obtain a permit or meet the conditions of a permit by rule; and 30 TAC §116.115(b)(2)(F) and §122.143(4), Permit Number 1829, General Condition Number 8, Federal Operating Permit (FOP) Number 1533, General Terms and Conditions (GTC) and Special Condition (SC) Number 13, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $24,075; Supplemental Environmental Project (SEP) offset amount of $9,630 applied to Texas Parent Teacher Association (PTA) - *Texas PTA Clean School Buses*; ENFORCEMENT COORDINATOR: Audra Benoit, (409) 898-3838; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(12) COMPANY: Indian Petro Corporation; DOCKET NUMBER: 2009-0368-MWD-E; IDENTIFIER: RN102080744; LOCATION: San Jacinto County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 TAC §305.125(1), Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0014035001, Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a), by failing to maintain compliance with the permit effluent limits for ammonia nitrogen; PENALTY: $4,640; ENFORCEMENT COORDINATOR: Heather Brister, (254) 751-0335; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(13) COMPANY: Joe Thurman Lodge & Livery, Inc.; DOCKET NUMBER: 2009-0159-PWS-E; IDENTIFIER: RN101380269; LOCATION: Goldthwaite, Mills County; TYPE OF FACILITY: PWS; RULE VIOLATED: 30 TAC §290.46(f)(3)(E)(i) and (n)(3), by failing to maintain and make available to the commission upon request an accurate and up-to-date record of water works operation and maintenance activities; 30 TAC §290.42(1), by failing to compile and maintain a complete and up-to-date operations manual; 30 TAC §290.43(c)(1), by failing to provide a 16-mesh or finer corrosion resistant screen for the roof vent on the ground storage tank; 30 TAC §290.43(c)(2), by failing to ensure that the roof access opening on the ground storage tank remains locked except during inspection and maintenance activities; 30 TAC §290.43(c)(3), by failing to provide the overflow on the ground storage tank with a gravity-hinged and weighted cover that fits tightly with no gap over 1/16-inch; 30 TAC §290.45(c)(1)(B)(iii) and THSC, §341.0315(c), by failing to provide two or more service pumps with a total capacity of one gallon per minute per unit; 30 TAC §290.46(n)(2), by failing to provide an accurate and up-to-date map of the distribution system so that valves and mains can be easily located during emergencies; 30 TAC §290.43(e), by failing to ensure all potable water storage tanks and pressure maintenance facilities are installed in lockable buildings; 30 TAC §290.46(m)(1)(A), by failing to conduct an annual inspection of the facility's ground storage tank; 30 TAC §290.46(m)(1)(B), by failing to conduct an annual inspection of the facility's three pressure tanks; and 30 TAC §290.46(h), by failing to keep a supply of calcium hypochlorite disinfectant on hand for use when making repairs, setting meters, and disinfecting new mains prior to placing them in service; PENALTY: $2,427; ENFORCEMENT COORDINATOR: Andrea Linson-Mgbeoduru, (512) 239-1482; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(14) COMPANY: KORI SERVICES, LIMITED dba Lakeway Valero; DOCKET NUMBER: 2009-0231-PST-E; IDENTIFIER: RN101491678; LOCATION: Lakeway, Travis County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to timely renew a previously issued UST delivery certificate by submitting a properly completed UST registration and self-certification form; 30 TAC §334.8(c)(5)(A)(i) and the Code, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate; 30 TAC §334.50(b)(1)(A) and the Code, §26.3475(c)(1), by failing to monitor USTs for releases; 30 TAC §334.50(b)(2) and the Code, §26.3475(a), by failing to provide proper release detection for the piping associated with the UST system; 30 TAC §334.50(b)(2)(A)(i)(III) and the Code, §26.3475(a), by failing to test the line leak detectors at least once per year for performance and operational reliability; 30 TAC §334.51(a)(6) and the Code, §26.3475(c)(2), by failing to ensure that all spill and overfill prevention devices are maintained in good operating condition; 30 TAC §115.222(3) and THSC, §382.085(b), by failing to comply with control requirements for emission limitation anywhere in the liquid transfer or vapor balance system; and 30 TAC §334.48(c), by failing to conduct effective manual or automatic inventory control procedures for all USTs; PENALTY: $21,759; ENFORCEMENT COORDINATOR: Mike Pace, (817) 588-5800; REGIONAL OFFICE: 2800 South IH 35, Suite 100, Austin, Texas 78704-5700, (512) 339-2929.

(15) COMPANY: LANXESS Corporation; DOCKET NUMBER: 2009-0172-AIR-E; IDENTIFIER: RN100825363; LOCATION: Orange, Orange County; TYPE OF FACILITY: chemical manufacturing plant; RULE VIOLATED: 30 TAC §116.115(b)(2)(F) and (c) and §122.143(4), FOP Number O-2282, GTC and SC Number 11, Air Permit Number 22508 and PSD-TX-874, SC Number 1, and THSC, §382.085(b), by failing to prevent unauthorized emissions; and 30 TAC §101.201(a)(1)(B) and §122.143(4), FOP Number O-2282, SC Number 2.F., and THSC, §382.085(b), by failing to report incident number 111300 within 24 hours after discovery; PENALTY: $4,524; SEP offset amount of $1,810 applied to Ducks Unlimited, Inc. - Reforestation and Enhancement of Tony Houseman State Park & Wildlife Management Area at Blue Elbow Swamp; ENFORCEMENT COORDINATOR: Rebecca Johnson, (361) 825-3100; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(16) COMPANY: Loop 12 Investment Corporation dba R Bar R Food Mart; DOCKET NUMBER: 2009-0229-PST-E; IDENTIFIER: RN104208939; LOCATION: Quinlan, Hunt County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to timely renew a previously issued UST delivery certificate by submitting a properly completed UST registration and self-certification form; 30 TAC §334.8(c)(5)(A)(i) and the Code, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate; 30 TAC §334.48(c), by failing to conduct effective manual or automatic inventory control procedures; 30 TAC §334.50(b)(1)(A) and the Code, §26.3475(c)(1), by failing to ensure that the UST is monitored in a manner which will detect a release; 30 TAC §334.50(b)(2) and the Code, §26.3475(a), by failing to provide release detection for the piping associated with the UST; 30 TAC §334.50(b)(2)(A)(i)(III) and the Code, §26.3475(a), by failing to test the line leak detector once per year for performance and operational reliability; 30 TAC §334.50(d)(1)(B)(ii) and the Code, §26.3475(c)(1), by failing to conduct reconciliation of detailed inventory control records at least once each month; 30 TAC §334.50(d)(1)(B)(iii)(I) and the Code, §26.3475(c)(1), by failing to record inventory volume measurement for regulated substance inputs, withdrawals, and the amount still remaining in the tank each operating day; 30 TAC §334.51(a)(6) and the Code, §26.3475(c)(2), by failing to ensure that all spill and overfill prevention devices are maintained in good operating condition and that such devices are inspected and serviced in accordance with manufacturers' specifications; and 30 TAC §334.45(c)(3)(A), by failing to install an emergency shutoff valve on each pressurized delivery or product line and ensure that it is securely anchored at the base of the dispenser; PENALTY: $10,097; ENFORCEMENT COORDINATOR: Judy Kluge, (817) 588-5800; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(17) COMPANY: TENET HOSPITALS LIMITED dba Providence Memorial Hospital; DOCKET NUMBER: 2009-0916-PST-E; IDENTIFIER: RN100223858; LOCATION: El Paso, El Paso County; TYPE OF FACILITY: hospital with backup diesel-powered electric generators; RULE VIOLATED: 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to timely renew a previously issued UST delivery certificate by submitting a properly completed UST registration and self-certification form; 30 TAC §334.8(c)(5)(A)(i) and the Code, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate; 30 TAC §334.72 and §334.76, by failing to report a release within 24 hours of discovery; and 30 TAC §334.75(a), by failing to immediately clean up a spill or overfill of a petroleum substance from a UST system and begin corrective action; PENALTY: $4,230; ENFORCEMENT COORDINATOR: Judy Kluge, (817) 588-5800; REGIONAL OFFICE: 401 East Franklin Avenue, Suite 560, El Paso, Texas 79901-1212, (915) 834-4949.

(18) COMPANY: Linda Key Torres; DOCKET NUMBER: 2009-0417-MSW-E; IDENTIFIER: RN105606453; LOCATION: Burleson, Johnson County; TYPE OF FACILITY: property; RULE VIOLATED: 30 TAC §330.15(c), by failing to prevent the unauthorized disposal of municipal solid waste; PENALTY: $1,120; ENFORCEMENT COORDINATOR: Keith Frank, (512) 239-1203; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(19) COMPANY: Town of Buckholts; DOCKET NUMBER: 2009-0534-MWD-E; IDENTIFIER: RN103014809; LOCATION: Milam County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(a), TPDES Permit Number WQ0011875001, Effluent Limitations and Monitoring Requirements Number 2, and the Code, §26.121(a), by failing to comply with the permitted effluent limitations for chlorine residual; PENALTY: $3,840; ENFORCEMENT COORDINATOR: Samuel Short, (512) 239-5363; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(20) COMPANY: Viridis Energy (Texas), LP; DOCKET NUMBER: 2009-0298-AIR-E; IDENTIFIER: RN102495421 and RN102663085; LOCATION: Humble and Baytown; Harris and Chambers Counties; TYPE OF FACILITY: landfill gas to electric generation plants; RULE VIOLATED: 30 TAC §122.143(4) and §122.145(2)(C), FOP Number O-02565, GTC, and THSC, §382.085(b), by failing to submit a deviation report; PENALTY: $5,500; ENFORCEMENT COORDINATOR: Miriam Hall, (512) 239-1044; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

TRD-200902293
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: June 9, 2009

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Notice of Opportunity to Comment on Agreed Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. Section 7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. Section 7.075 requires that notice of the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **July 20, 2009.** Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the attorney designated for the AO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on July 20, 2009.** Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The designated attorney is available to discuss the AO and/or the comment procedure at the listed phone number; however, §7.075 provides that comments on an AO shall be submitted to the commission in **writing.**

(1) COMPANY: David Fenoglio dba Sunset Water System; DOCKET NUMBER: 2007-1711-PWS-E; TCEQ ID NUMBER: RN102693579; LOCATION: Corner of West Front Street and Cottage Grove Avenue, near Railroad Tracks, 11243 Highway 59N, Montague, Montague County; TYPE OF FACILITY: public water system; RULES VIOLATED: 30 TAC §290.46(f)(2) and TCEQ Order Docket Number 2003-0038-PWS-E, Ordering Provision 3.e., by failing to keep on file and make available for commission review records of annual tank inspections; 30 TAC §290.46(n)(3) and TCEQ Order Docket Number

2003-0038-PWS-E, Ordering Provision 3.f., by failing to keep on file and make available for commission review, copies of well completion data records; 30 TAC §290.45(b)(1)(C)(ii) and TCEQ Order Docket Number 2003-0038-PWS-E, Ordering Provision 5.b., and Texas Health and Safety Code, §341.0315(c), by failing to provide a total storage capacity of 200 gallons per connection; 30 TAC §290.43(c)(2), by failing to provide 30-inch access openings on the three ground storage tanks; 30 TAC §290.46(m)(1)(B), by failing to inspect the interior of the pressure tanks that are provided with an inspection port at least once every five years; 30 TAC §290.42(1), by failing to maintain a thorough and up-to-date plant operations manual for operator review and reference; 30 TAC §290.46(u) and TCEQ Docket Number 2003-0038-PWS-E, Ordering Provision 5.c., by failing to plug Well Number 2 and Number 3 or to submit test results proving that the wells are in a non-deteriorated condition; PENALTY: $10,210; STAFF ATTORNEY: Jacquelyn Boutwell, Litigation Division, MC 175, (512) 239-5846; REGIONAL OFFICE: Abilene Regional Office, 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(2) COMPANY: MBE, Inc. dba Bryan's 2; DOCKET NUMBER: 2003-1144-PST-E; TCEQ ID NUMBER: RN102375557; LOCATION: 901 East Main, San Augustine, San Augustine County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.48(c), by failing to conduct inventory control for all underground storage tanks involved in the retail sale of petroleum substances used as motor fuel; PENALTY: $5,100; STAFF ATTORNEY: Jacquelyn Boutwell, Litigation Division, MC 175, (512) 239-5846; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(3) COMPANY: Valero Refining - Texas, L.P.; DOCKET NUMBER: 2007-1813-MLM-E; TCEQ ID NUMBER: RN100211663 and RN100238385; LOCATION: 1300 Cantwell Lane, Corpus Christi, Nueces County (Plant 1) and 1301 Loop 197 South, Texas City, Galveston County (Plant 2); TYPE OF FACILITY: oil refinery; RULES VIOLATED: 30 TAC §335.4 and §335.43(a) and TWC, §26.121(a), by failing at Plant 1 to prevent the unauthorized discharge and accumulation of untreated hazardous wastewater on the ground; 30 TAC §335.69(a)(1)(B), by failing at Plant 1 to comply with hazardous waste tank requirements including, but not limited to, the structural integrity of the tank, compatibility with the waste(s) being stored, and corrosion protection; 30 TAC §101.20(3) and §116.715(a), Texas Health and Safety Code, §382.085(b), and Air Permit Numbers PSD-TX-1023M1 and 2937, Special Condition 18, by failing at Plant 1 to maintain compliance with the emission limits; 30 TAC §101.222, by failing at Plant 2 to prevent unauthorized emissions during a December 11, 2006, emissions event in the Toppers Unit, Number 3 Crude Unit, fluidized catalytic cracking unit (FCCU), Alkylation Unit and the Numbers 1, 2, 3, and 4 Flare Stacks over a period of 33 hours and 30 minutes, 18,329 pounds (lbs) of sulfur dioxide, 11,798 lbs of volatile organic compounds, and 6,229.90 lbs of carbon monoxide; and 30 TAC §101.222, by failing at Plant 2 to prevent unauthorized emissions during a January 19, 2007, emissions event in the FCCU; 30 TAC §101.222, by failing to prevent unauthorized emissions during a March 4, 2007, emissions event in the Sats Gas Unit; PENALTY: $108,900; Supplemental Environmental Project offset amount of $54,450 applied to Keep Texas Beautify Texas Waterways Cleanup Program; STAFF ATTORNEY: Jacquelyn Boutwell, Litigation Division, MC 175, (512) 239-5846; REGIONAL OFFICE: Corpus Christi Regional Office, 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

TRD-200902297

Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: June 9, 2009

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Notice of Water Quality Applications

The following notices were issued during the period of June 2, 2009 through June 4, 2009.

The following require the applicants to publish notice in a newspaper. Public comments, requests for public meetings, or requests for a contested case hearing may be submitted to the Office of the Chief Clerk, Mail Code 105, P.O. Box 13087, Austin, Texas 78711-3087, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THE NOTICE.

INFORMATION SECTION

BTB REFINING INC which operates a petroleum refinery, has applied for a renewal of TPDES Permit No. WQ0002720000, which authorizes a discharge of treated process wastewater, treated storm water, water softener blowdown, cooling tower blowdown, boiler blowdown, and hydrostatic test water at a daily average flow not to exceed 120,000 gallons per day via Outfall 001; and storm water on an intermittent and flow variable basis via Outfall 002. The facility is located at 6600 Up River Road, on the north side of Up River Road approximately one-half mile west of the intersection of Up River Road and Valero Way, northwest of the City of Corpus Christi, Nueces County, Texas.

COLORADO RIVER MUNICIPAL WATER DISTRICT which proposes to operate Colorado River MWD Big Spring Water Reclamation Plant, a water reclamation facility, has applied for a new permit, proposed Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0004872000, to authorize the discharge of reverse osmosis concentrate at a daily average flow not to exceed 525,000 gallons per day via Outfall 001. The facility is located west of the Big Spring Wastewater Treatment Plant on the north side of Eleventh Place, approximately 800 feet east of the intersection of Farm-to-Market Road 700 and Eleventh Place, and approximately 0.6 mile south of the intersection of Farm-to-Market Road 700 and Interstate Highway 20 in the city of Big Spring, Howard County, Texas.

CITY OF OLNEY has applied for a renewal of TPDES Permit No. WQ0010050001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 790,000 gallons per day. The facility is located approximately 0.25 mile east of the state highway 79 and 1.0 mile south of US 380 in Young County, Texas.

THE CITY OF MUNDAY has applied for a renewal of TPDES Permit No. WQ0010228002, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 200,000 gallons per day. The facility is located immediately south of Farm-to-Market Road 1587 approximately 2.3 miles northwest of the intersection of Farm-to-Market 1587 and Farm-to-Market Road 266 in Knox County, Texas.

TWINWOOD INC has applied for a renewal of TPDES Permit No. WQ0013089001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 100,000 gallons per day. The facility will be located between Guyler Road and Brundrett Road, approximately 1.5 miles southwest of the City Simonton and the intersection of Farm-to-Market Roads 1093 and 1489 in Fort Bend County, Texas.

TEXAS PARKS AND WILDLIFE DEPARTMENT has applied for a renewal of TCEQ Permit No. WQ0014676001, which authorizes the

disposal of treated domestic wastewater at a daily average flow not to exceed 10,050 gallons per day via surface irrigation of 3.63 acres of non-public access land. This permit will not authorize a discharge of pollutants into waters in the State. The wastewater treatment facility and disposal site are located within the Lake Brownwood State Park, 1.42 miles east of the intersection of park Road 15 and Farm-to-Market Road 2559 in Brown County, Texas. The wastewater treatment facility and disposal site are located in the drainage basin of Lake Brownwood in Segment No. 1418 of the Colorado River Basin.

If you need more information about these permit applications or the permitting process, please call the TCEQ Office of Public Assistance, Toll Free, at 1-800-687-4040. General information about the TCEQ can be found at our web site at www.tceq.state.tx.us. Si desea información en Español, puede llamar al 1-800-687-4040.

TRD-200902316
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: June 10, 2009

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Texas Facilities Commission

Request for Proposals #303-9-11838

The Texas Facilities Commission (TFC), on behalf of the Texas Parks and Wildlife Department (TPWD), announces the issuance of Request for Proposals (RFP) #303-9-11838. TFC seeks a five (5) year lease of approximately 866 square feet of office space in Pleasanton, Atascosa, Texas.

The deadline for questions is June 26, 2009, and the deadline for proposals is July 7, 2009, at 3:00 p.m. The award date is August 19, 2009. TFC reserves the right to accept or reject any or all proposals submitted. TFC is under no legal or other obligation to execute a lease on the basis of this notice or the distribution of an RFP. Neither this notice nor the RFP commits TFC to pay for any costs incurred prior to the award of a grant.

Parties interested in submitting a proposal may obtain information by contacting TFC Purchaser Sandy Williams at (512) 475-0453. A copy of the RFP may be downloaded from the Electronic State Business Daily at *http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=83045.*

TRD-200902320
Kay Molina
General Counsel
Texas Facilities Commission
Filed: June 10, 2009

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Texas Health and Human Services Commission

Notice of Public Hearing on Proposed Medicaid Payment Rates

Hearing. The Texas Health and Human Services Commission (HHSC) will conduct a public hearing on July 15, 2009, at 1:30 p.m., to receive comment on proposed Medicaid payment rate for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Personal Care Services (PCS) for Type of Service (TOS) 1. The public hearing will be held in the Lone Star Conference Room of HHSC, Braker Center, Building H, located at 11209 Metric Boulevard, Austin, Texas. Entry is through Security at the main entrance of the building, which faces Metric Boulevard. The hearing will be held in compliance with Human Resources Code §32.0282 and Texas Administrative Code (TAC) Title 1, §355.201(e) - (f), which require public notice of and hearings on proposed Medicaid reimbursements.

Proposal. The proposed payment rates for PCS in the EPSDT services program are proposed to be effective September 1, 2009.

Methodology and Justification. The proposed payment rates were calculated in accordance with 1 TAC §355.8441(12)(B), which addresses the reimbursement methodologies for PCS under the EPSDT services program.

Briefing Package. A briefing package describing the proposed payment rates will be available on or after June 30, 2009. Interested parties may obtain a copy of the briefing package prior to the hearing by contacting Rate Analysis by telephone at (512) 491-1445; by fax at (512) 491-1983; or by e-mail at meisha.scott@hhsc.state.tx.us. The briefing package also will be available at the public hearing.

Written Comments. Written comments regarding the proposed payment rates may be submitted in lieu of, or in addition to, oral testimony until 5 p.m. the day of the hearing. Written comments may be sent by U.S. mail to the attention of Rate Analysis, HHSC, Rate Analysis, Mail Code H-400, P.O. Box 85200, Austin, Texas 78708-5200; by fax to Rate Analysis at (512) 491-1983; or by e-mail to meisha.scott@hhsc.state.tx.us. In addition, written comments may be sent by overnight mail or hand delivered to HHSC Rate Analysis, Mail Code H-400, Braker Center, Building H, 11209 Metric Boulevard, Austin, Texas 78758-4021.

Persons with disabilities who wish to attend the hearing and require auxiliary aids or services should contact Rate Analysis at (512) 491-1445 at least 72 hours in advance, so appropriate arrangements can be made.

TRD-200902220
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: June 4, 2009

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Notice of Public Hearing on Proposed Medicaid Payment Rates

Hearing. The Texas Health and Human Services Commission (HHSC) will conduct a public hearing on July 15, 2009, at 1:30 p.m., to receive comment on proposed Medicaid payment rates for Ambulance Services associated with the 81st Legislative Session. The public hearing will be held in the Lone Star Conference Room of HHSC, Braker Center, Building H, located at 11209 Metric Boulevard, Austin, Texas. Entry is through Security at the main entrance of the building, which faces Metric Boulevard. The hearing will be held in compliance with Human Resources Code §32.0282 and 1 Texas Administrative Code (TAC) §355.201(e) - (f), which require public notice of and hearings on proposed Medicaid reimbursements.

Proposal. The proposed payment rates for Ambulance Services are proposed to be effective September 1, 2009.

Methodology and Justification. The proposed payment rates were calculated in accordance with 1 TAC §355.8600, which addresses the reimbursement methodology for Ambulance Services.

Briefing Package. A briefing package describing the proposed payment rates will be available on or after June 30, 2009. Interested parties may obtain a copy of the briefing package prior to the hearing by contacting Rate Analysis by telephone at (512) 491-1445; by fax at (512) 491-1983; or by e-mail at meisha.scott@hhsc.state.tx.us. The briefing package also will be available at the public hearing.

Written Comments. Written comments regarding the proposed payment rates may be submitted in lieu of, or in addition to, oral testimony until 5:00 p.m. the day of the hearing. Written comments may be sent by U.S. mail to the attention of Rate Analysis, HHSC, Rate Analysis, Mail Code H-400, P.O. Box 85200, Austin, Texas 78708-5200; by fax to Rate Analysis at (512) 491-1983; or by e-mail to meisha.scott@hhsc.state.tx.us. In addition, written comments may be sent by overnight mail or hand delivered to HHSC Rate Analysis, Mail Code H-400, Braker Center, Building H, 11209 Metric Boulevard, Austin, Texas 78758-4021.

Persons with disabilities who wish to attend the hearing and require auxiliary aids or services should contact Rate Analysis at (512) 491-1445 at least 72 hours in advance, so appropriate arrangements can be made.

TRD-200902221
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: June 4, 2009

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Notice of Public Hearing on Proposed Medicaid Payment Rates

Hearing. The Texas Health and Human Services Commission (HHSC) will conduct a public hearing on July 15, 2009, at 1:30 p.m., to receive comment on proposed Medicaid payment rates for Certified Nurse Midwife (CNM) services in a birthing center for types of service (TOS) 1 and 2. The public hearing will be held in the Lone Star Conference Room of HHSC, Braker Center, Building H, located at 11209 Metric Boulevard, Austin, Texas. Entry is through Security at the main entrance of the building, which faces Metric Boulevard. The hearing will be held in compliance with Human Resources Code §32.0282 and Texas Administrative Code (TAC) Title 1, §355.201(e) - (f), which require public notice of and hearings on proposed Medicaid reimbursements.

Proposal. The proposed payment rates for Certified Nurse Midwife services in a birthing center are proposed to be effective May 16, 2009.

Methodology and Justification. The proposed payment rates were calculated in accordance with 1 TAC §355.8085, which addresses the reimbursement methodology for physician and certain other practitioners.

Briefing Package. A briefing package describing the proposed payment rates will be available on or after June 30, 2009. Interested parties may obtain a copy of the briefing package prior to the hearing by contacting Rate Analysis by telephone at (512) 491-1445; by fax at (512) 491-1983; or by e-mail at meisha.scott@hhsc.state.tx.us. The briefing package also will be available at the public hearing.

Written Comments. Written comments regarding the proposed payment rates may be submitted in lieu of, or in addition to, oral testimony until 5:00 p.m. the day of the hearing. Written comments may be sent by U.S. mail to the attention of Rate Analysis, HHSC, Rate Analysis, Mail Code H-400, P.O. Box 85200, Austin, Texas 78708-5200; by fax to Rate Analysis at (512) 491-1983; or by e-mail to meisha.scott@hhsc.state.tx.us. In addition, written comments may be sent by overnight mail or hand delivered to HHSC Rate Analysis, Mail Code H-400, Braker Center, Building H, 11209 Metric Boulevard, Austin, Texas 78758-4021.

Persons with disabilities who wish to attend the hearing and require auxiliary aids or services should contact Rate Analysis at (512) 491-1445 at least 72 hours in advance, so appropriate arrangements can be made.

TRD-200902222
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: June 4, 2009

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Public Notice

The Texas Health and Human Services Commission announces its intent to submit amendments to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendments are effective September 1, 2009.

The amendments will modify the reimbursement methodologies in the Texas Medicaid State Plan as a result of Medicaid fee changes for the following services:

Ambulance Services Texas Health Steps (THSteps) Personal Care Services (PCS)

The proposed amendments are estimated to result in an additional annual aggregate expenditure of $1,134,539 for federal fiscal year (FFY) 2009, with approximately $780,109 in federal funds and $354,430 in State General Revenue (GR). For FFY 2010, the estimated additional aggregate expenditure is $14,176,071, with approximately $9,901,985 in federal funds and $4,274,086 in GR. For FFY 2011, the estimated additional aggregate expenditure is $15,338,814, with approximately $9,460,980 in federal funds and $5,877,834 in GR.

Interested parties may obtain copies of the proposed amendment by contacting Dan Huggins, Director of Rate Analysis for Acute Care Services, by mail at the Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, H-400, Austin, Texas 78708-5200; by telephone at (512) 491-1432; by facsimile at (512) 491-1998; or by e-mail at Dan.Huggins@hhsc.state.tx.us. Copies of the proposals will also be made available for public review at the local offices of the Texas Department of Aging and Disability Services.

TRD-200902234
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: June 4, 2009

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Public Notice

The Texas Health and Human Services Commission announces its intent to submit an amendment to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendments are effective September 1, 2009.

The amendments will modify the reimbursement methodologies in the Texas Medicaid State Plan as a result of Medicaid fee changes for the following services:

Tuberculosis (TB) Clinic Services

The proposed amendment is estimated to result in an annual aggregate expenditure of $52,982 for the remainder of federal fiscal year (FFY) 2009, with approximately $36,430 in federal funds and $16,552 in state funds. For FFY 2010, the estimated additional aggregate expenditure is $213,650, with approximately $149,234 in federal funds and $64,416 in state funds. For FFY 2011, the estimated additional aggregate expenditure is $229,331, with approximately $141,451 in federal funds and $87,880 in state funds.

Interested parties may obtain copies of the proposed amendment by contacting Chris Dockal, Hospital Reimbursement, by mail at the Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, H-400, Austin, Texas 78708-5200; by telephone at (512) 491-1467; by facsimile at (512) 491-1998; or by e-mail at chris.dockal@hhsc.state.tx.us. Copies of the proposal will also be made available for public review at the local offices of the Texas Department of Aging and Disability Services.

TRD-200902318
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: June 10, 2009

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Department of State Health Services

Licensing Actions for Radioactive Materials

The Department of State Health Services has taken actions regarding Licenses for the possession and use of radioactive materials as listed in the tables. The subheading "location" indicates the city in which the radioactive material may be possessed and/or used. The location listing "Throughout Texas" indicates that the radioactive material may be used on a temporary basis at job sites throughout the state.

NEW LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Dallas	Texas Oncology P.A.	L06240	Dallas	00	05/19/09

AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Arlington	The University of Texas at Arlington	L00248	Arlington	48	05/21/09
Arlington	G.E. Healthcare	L05693	Arlington	08	05/27/09
Arlington	Metroplex Hematology Oncology Associates dba Arlington Cancer Center	L03211	Arlington	84	05/28/09
Austin	Seton Healthcare dba Dell Children's Medical Center of Central Texas	L06065	Austin	12	05/19/09
Austin	Seton Healthcare dba Seton Medical Center Austin	L02896	Austin	103	05/14/09
Austin	Texas Oncology P.A.	L05108	Austin	21	05/18/09
Austin	Texas Oncology P.A.	L06206	Austin	01	05/18/09
Austin	Seton Healthcare dba Seton Medical Center Austin	L06128	Austin	08	05/13/09
Austin	Austin Diagnostic Clinic	L05646	Austin	12	05/26/09
Austin	Austin Heart P.A.	L04623	Austin	62	05/27/09
Austin	Seton Healthcare dba University Medical Center at Brackenridge	L00268	Austin	106	05/27/09
Austin	Seton Healthcare dba University Medical Center at Brackenridge	L00268	Austin	107	05/29/09
Baytown	Exxon Mobil Refining and Supply Company	L01134	Baytown	65	05/26/09
Baytown	San Jacinto Methodist Hospital	L02388	Baytown	59	05/28/09
Beaumont	The Goodyear Tire & Rubber Company Beaumont Chemical Plant	L06063	Beaumont	02	05/21/09
Beaumont	Metalforms Inc.	L02261	Beaumont	39	05/26/09
Borger	Chevron Phillips Chemical Company L.P.	L05181	Borger	15	05/20/09
College Station	Texas A&M University	L05683	College Station	10	05/28/09
Corpus Christi	Sherwin Alumina L.P.	L00200	Corpus Christi	47	05/19/09
Dallas	Baylor University Medical Center	L01290	Dallas	95	05/29/09
Dallas	Medical Services/Dallas Nephrology Association	L02604	Dallas	27	05/19/09
Dallas	Mallinckrodt Inc.	L03580	Dallas	64	05/22/09
Dallas	IBA Molecular North America Inc. dba IBA Molecular	L06174	Dallas	03	05/20/09
Dallas	Medi-Physics Inc. dba G.E. Healthcare	L05529	Dallas	27	05/21/09
Dallas	Texas Hematology/Oncology Center P.A. dba Patient's Comprehensive Cancer Center	L05397	Dallas	18	05/29/09
El Paso	El Paso Healthcare System L.P. dba Del Sol Diagnostic Center	L03395	El Paso	46	05/20/09
El Paso	R. E. Thomason General Hospital	L00502	El Paso	62	05/22/09
El Paso	El Paso Heart Center	L04828	El Paso	18	05/22/09
Fort Worth	Texas Health Harris Methodist Hospital Fort Worth	L01837	Fort Worth	118	05/15/09
Fort Worth	Radiology Associates	L03953	Fort Worth	47	05/18/09

AMENDMENTS TO EXISTING LICENSES ISSUED (Continued):

Location	Name	License #	City	Amend-ment #	Date of Action
Fort Worth	Oncology Hematology Consultants P.A. dba The Center for Cancer and Blood Disorders	L05919	Fort Worth	09	05/15/09
Fort Worth	Texas Christian University	L01096	Fort Worth	41	05/22/09
Fort Worth	Physicians Surgical Center of Fort Worth dba Physicians Surgical Center Fort Worth	L05863	Fort Worth	05	05/22/09
Grapevine	Cardiology Specialties	L05779	Grapevine	03	05/28/09
Houston	NIS Holdings Inc. dba Nuclear Imaging Services	L05775	Houston	51	05/20/09
Houston	Kelsey Seybold Clinic P.A.	L00391	Houston	66	05/18/09
Houston	CHCA Women's Hospital L.P. dba The Women's Hospital of Texas	L04834	Houston	16	05/18/09
Houston	NIS Holdings Inc. dba Nuclear Imaging Services	L05775	Houston	50	05/18/09
Houston	Columbia/HCA Healthcare Corporation dba Spring Branch Medical Center	L02473	Houston	71	05/14/09
Houston	Memorial Hermann Hospital System dba River Oaks Imaging and Diagnostic	L06181	Houston	06	05/22/09
Houston	Gulf Coast MRI & Diagnostic	L05333	Houston	15	05/29/09
Irving	Healthcare Associates of Irving L.P.	L05371	Irving	07	05/19/09
Laredo	Laredo Regional Medical Center L.P. dba Doctors Hospital of Laredo	L02192	Laredo	35	05/20/09
Lubbock	Methodist Diagnostic Imaging dba Covenant Diagnostic Imaging	L03948	Lubbock	43	05/15/09
Marshall	Harrison County Hospital Association dba Good Shepard Medical Center-Marshall	L02572	Marshall	28	05/20/09
McAllen	Texas Oncology P.A. dba South Texas Cancer Center at McAllen	L04880	McAllen	10	05/19/09
Mesquite	Texas Oncology P.A. dba Texas Cancer Center Mesquite	L05741	Mesquite	07	05/20/09
Nacogdoches	Nacogdoches Medical Center	L02853	Nacogdoches	41	05/28/09
New Braunfels	Cancer Care Network of South Texas P.A.	L05717	New Braunfels	12	05/11/09
Pasadena	Kaneka Texas Corporation	L05050	Pasadena	06	05/20/09
Plano	Physician Reliance Network Inc. dba Texas Oncology Plano West Cancer Center	L05896	Plano	16	05/13/09
Ponco City, OK	Conoco Phillips Pipe Line Company dba Petroleum Transportation	L02083	Ponca City, OK	22	05/27/09
Port Lavaca	Union Carbide Corporation	L00051	Port Lavaca	93	05/26/09
Queen City	International Paper Company	L01686	Queen City	34	05/28/09
Richardson	Medical Edge Healthcare Group P.A. dba PET/CT Center of Richardson	L05688	Richardson	09	05/15/09
Round Rock	Scott and White Community Hospital Corporation dba Scott and White Healthcare-Round Rock	L06085	Round Rock	03	05/27/09
San Angelo	San Angelo Hospital L.P. dba San Angelo Community Medical Center	L02487	San Angelo	44	05/20/09
San Angelo	San Angelo Hospital L.P. dba San Angelo Community Medical Center	L02487	San Angelo	45	05/28/09
San Antonio	Methodist Healthcare System of San Antonio Ltd. L.L.P	L00594	San Antonio	258	05/27/09
Snyder	Scurry County Hospital District dba Cogdell Memorial Hospital	L02409	Snyder	32	05/29/09
Sulphur Springs	Medical Surgical Clinic of Sulphur Springs dba Sulphur Springs Family Health Care Associates	L05701	Sulphur Springs	15	05/27/09
Texarkana	Collom & Carney Clinic Association	L05524	Texarkana	04	05/28/09

AMENDMENTS TO EXISTING LICENSES ISSUED (Continued):

Location	Name	License #	City	Amend-ment #	Date of Action
The Woodlands	Memorial Hermann Hospital System dba Memorial Herman Hospital - The Woodlands	L03772	The Woodlands	71	05/25/09
Throughout Tx	Team Industrial Services Inc.	L00087	Alvin	206	05/22/09
Throughout Tx	Texas Department of State Health Services Community Preparedness Section	L05865	Austin	06	05/19/09
Throughout Tx	Applied Standards Inspection Inc.	L03072	Beaumont	111	05/15/09
Throughout Tx	AECOM Technical Services Inc.	L05449	Brooks City-Base	08	05/21/09
Throughout Tx	Brazos Valley Inspection Services Inc	L02859	Bryan	69	05/29/09
Throughout Tx	Integrity Testing & Inspection Inc.	L06027	El Paso	07	05/19/09
Throughout Tx	H & H X-Ray Services Inc.	L02516	Flint	79	05/18/09
Throughout Tx	Waggoner & Associates Inc. dba Waggoner-Texas & Associates Inc.	L06159	Flint	08	05/19/09
Throughout Tx	Pioneer Wireline Services L.L.C.	L06200	Graham	01	05/26/09
Throughout Tx	Rio Grand Resource Corporation	L06151	Hobson	02	05/26/09
Throughout Tx	Halliburton Energy Services Inc.	L02113	Houston	113	05/28/09
Throughout Tx	Paradigm Consultants Inc.	L04875	Houston	06	05/20/09
Throughout Tx	Professional Services Industries Inc.	L00203	Houston	124	05/22/09
Throughout Tx	QC Laboratories Inc.	L04750	Houston	23	05/21/09
Throughout Tx	Southern Services Inc. dba Southern Technical Services dba Bix Testing Laboratories	L05270	Lake Jackson	53	05/27/09
Throughout Tx	Eagle X-Ray Inc.	L03246	Mont Belvieu	100	05/19/09
Throughout Tx	Conam Inspection & Engineering Inc.	L05010	Pasadena	168	05/26/09
Throughout Tx	Furgo Consultants Inc.	L04322	Pasadena	99	05/20/09
Throughout Tx	TechCorr USA L.L.C.	L05972	Pasadena	61	05/26/09
Throughout Tx	Midwest Inspection Services	L03120	Perrytown	116	05/22/09
Throughout Tx	Total Petrochemicals USA Inc.	L03498	Port Arthur	25	05/21/09
Throughout Tx	Intec	L05150	San Antonio	13	05/28/09
Throughout Tx	Clough Harbour & Associates L.L.P.	L05355	Sanger	24	05/26/09
Throughout Tx	Schlumberger Technology Corporation	L00764	Sugar Land	112	05/18/09
Throughout Tx	B.J. Services Company USA	L02684	Tomball	63	05/22/09
Throughout Tx	City of Weatherford Community Development	L04571	Weatherford	09	05/20/09
Tyler	Carter Blood Care	L04826	Tyler	14	05/13/09
Waco	Baylor University	L00343	Waco	28	05/20/09
Weatherford	Medical and Heart Center P.A.	L05573	Weatherford	04	05/18/09

RENEWAL OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Jacksonville	Mother Frances Hospital Jacksonville	L05362	Jacksonville	26	05/22/09

TERMINATIONS OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Fort Worth	HealthSouth of Texas Inc. dba Baylor All Saints Gamma Knife Center	L05473	Fort Worth	26	05/22/09
Throughout Tx	Adams Brothers Inc.	L04771	Athens	09	05/20/09
Tomball	Chase Environmental Group Inc. dba Chase Remide	L05787	Tomball	04	05/21/09

In issuing new licenses, amending and renewing existing licenses, or approving license exemptions, the Department of State Health Services (department), Radiation Safety Licensing Branch, has determined that the applicant has complied with the applicable provisions of 25 Texas Administrative Code (TAC) Chapter 289, regarding radiation control. In granting termination of licenses, the department has determined that the licensee has complied with the applicable decommissioning requirements of 25 TAC Chapter 289. In denying the application for a license, license renewal or license amendment, the department has determined that the applicant has not met the applicable requirements of 25 TAC Chapter 289.

This notice affords the opportunity for a hearing on written request of a person affected within 30 days of the date of publication of this notice. A person affected is defined as a person who demonstrates that the person has suffered or will suffer actual injury or economic damage and, if the person is not a local government, is (a) a resident of a county, or a county adjacent to the county, in which radioactive material is or will be located, or (b) doing business or has a legal interest in land in the county or adjacent county. A person affected may request a hearing by writing Richard A. Ratliff, Radiation Program Officer, Department of State Health Services, Radiation Material Licensing - MC 2835, P.O. Box 149347, Austin, Texas 78714-9347. For information call (512) 834-6688.

TRD-200902265
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: June 5, 2009

♦ ♦ ♦

Texas Department of Insurance

Company Licensing

Application to change the name of STATE AND COUNTY MUTUAL FIRE INSURANCE COMPANY to HALLMARK COUNTY MUTUAL INSURANCE COMPANY, a domestic fire and casualty company. The home office is in Waco, Texas.

Any objections must be filed with the Texas Department of Insurance, within twenty (20) calendar days from the date of the *Texas Register* publication, addressed to the attention of Godwin Ohaechesi, 333 Guadalupe Street, M/C 305-2C, Austin, Texas 78701.

TRD-200902317
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: June 10, 2009

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Panhandle Regional Planning Commission

Request for Proposals

The Panhandle Regional Planning Commission (PRPC) is seeking proposals for a leased facility to house the Workforce Solutions Panhandle office in Pampa, Texas. The space should offer approximately 2,500 to 4,000 square feet of contiguous space that can be appropriately configured for business/professional use. The office is currently located at 1327 N. Hobart.

A copy of the Request for Proposals can be obtained by contacting Leslie Hardin, PRPC's Workforce Development Facilities Coordinator, at (806) 372-3381 or lhardin@theprpc.org. Proposals must be received at PRPC by 3:00 p.m. on July 6, 2009.

TRD-200902275
Leslie Hardin
WFD Facilities, Training and Support Coordinator
Panhandle Regional Planning Commission
Filed: June 8, 2009

♦ ♦ ♦

Public Utility Commission of Texas

Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on June 3, 2009, for an amendment to a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Etan Industries, Inc. d/b/a CMA Communications for an Amendment to its StateIssued Certificate of Franchise Authority, Project Number 37074 before the Public Utility Commission of Texas.

The requested amendment is to expand the service area footprint to include the city limits of Hempstead.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All inquiries should reference Project Number 37074.

TRD-200902301
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: June 9, 2009

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Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on June 4, 2009, for an amendment to a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Northland Cable Ventures LLC for an Amendment to its State-Issued Certificate of Franchise Authority, Project Number 37078 before the Public Utility Commission of Texas.

The requested amendment is to expand the service area footprint to include the city limits of Chandler, Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text tele-

phone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All inquiries should reference Project Number 37078.

TRD-200902303
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: June 9, 2009

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Announcement of Application for State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on June 3, 2009, for a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Brazos Cable TV for a State-Issued Certificate of Franchise Authority, Project Number 37076 before the Public Utility Commission of Texas.

The requested CFA service area includes the area within a boundary extending 600 feet beyond the city limits of Olney, Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All inquiries should reference Project Number 37076.

TRD-200902302
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: June 9, 2009

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Notice of Application for Amendment to Designation as an Eligible Telecommunications Carrier and Request for Designation as an Eligible Telecommunications Providers

Notice is given to the public of an application filed with the Public Utility Commission of Texas (commission) on June 8, 2009, for an amendment to its designation as an eligible telecommunications carrier (ETC) and request for designation as an eligible telecommunications provider (ETP) pursuant to P.U.C. Substantive Rule §26.418 and §26.417, respectively.

Docket Title and Number: Application of USFon, Inc. for Amendment to its Designation as an Eligible Telecommunications Carrier and Request for Designation as an Eligible Telecommunications Provider; Docket Number 37090.

The Application: The company is requesting an amendment of its ETC designation to cover all areas where Southwestern Bell Telephone Company d//b/a AT&T Texas (AT&T Texas) has coverage in order to receive support from the Federal Universal Service Fund, and ETP designation in all areas where AT&T Texas has coverage in order to receive support from the Texas Universal Service Fund. Pursuant to 47 U.S.C. §214(e) and P.U.C. Substantive Rule §26.417, the commission, either upon its own motion or upon request, shall designate qualifying common carriers as ETCs and ETPs for service areas set forth by the commission.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by July 9, 2009. Requests for further information should be mailed to the Public Utility Commission of Texas, P.O. Box 13326, Austin, Texas 78711-3326, or you may call the Public Utility Commission's Customer Protection Division at (512) 936-7120 or (888) 782-8477. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (800) 735-2989 to reach the commission's toll free number (888) 782-8477. All comments should reference Docket Number 37090.

TRD-200902304
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: June 9, 2009

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Notice of Application for Amendment to Service Provider Certificate of Operating Authority

On June 1, 2009, NextG Networks of Illinois, Inc. d/b/a NextG Networks Central filed an application with the Public Utility Commission of Texas (commission) to amend its service provider certificate of operating authority (SPCOA) granted in SPCOA Certificate Number 60717. Applicant intends to reflect a change in ownership/control.

The Application: Application of NextG Networks of Illinois, Inc. d/b/a NextG Networks Central for an Amendment to its Service Provider Certificate of Operating Authority, Docket Number 37063.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than June 24, 2009. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 37063.

TRD-200902233
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: June 4, 2009

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Notice of Application for Service Provider Certificate of Operating Authority

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of an application on June 1, 2009, for a service provider certificate of operating authority (SPCOA), pursuant to §§54.151 - 54.156 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of OSN CLEC for a Service Provider Certificate of Operating Authority, Docket Number 37064 before the Public Utility Commission of Texas.

Applicant intends to provide plain old telephone service, ADSL, ISDN, HDSL, SDSL, RADSL, VDSL, Optical Services, T1-Private Line, Switch 56 KBPS, Frame Relay, Fractional T1, long distance, wireless and Ethernet services.

Applicant's requested SPCOA geographic area includes the area of Texas currently served by Southwestern Bell Telephone Company d/b/a AT&T Texas, Verizon Southwest, and Embarq.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than June 24, 2009. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 37064.

TRD-200902232
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: June 4, 2009

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Notice of Application to Amend Certificated Service Area Boundaries

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of an application filed on June 1, 2009, for an amendment to certificated service area boundaries within Cameron County, Texas.

Docket Style and Number: Application of the Brownsville Public Utilities Board (BPUB) to Amend a Certificate of Convenience and Necessity for Service Area Boundaries within Cameron County (Texas Meats). Docket Number 37068.

The Application: The application encompasses an area of land which is singly certificated to American Electric Power Company (AEP), formerly known as Central Power & Light (CP&L), and is within the corporate limits of the City of Brownsville. BPUB received a letter request from Olga Cruz, owner of Texas Meats, requesting BPUB to provide electric utility service to her business. The estimated cost to BPUB to provide service to this proposed area is $6,396.00. The area is presently developed and distribution facilities will not need to be constructed in order to provide service. If the application is granted, the area would be dually certificated for electric service.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas no later than June 26, 2009, by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 37068.

TRD-200902219
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: June 3, 2009

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Public Notice of Workshop on the Storm Hardening Benchmark Studies and Request for Comments

The staff of the Public Utility Commission of Texas (commission) will hold a workshop regarding the Storm Hardening Benchmark Studies on Wednesday, July 8, 2009 at 9:00 a.m. in the Commissioner's Hearing Room, located on the 7th floor of the William B. Travis Building, 1701 North Congress Avenue, Austin, Texas 78701. Project Number 36375, *Cost Benefit Analysis of the Deployment of Utility Infrastructure Upgrades and Storm Hardening Programs,* has been established for this proceeding. Please refer to the Hazard Trees Benchmark Survey and Best Practices Preliminary Draft Report, currently filed under Project Number 36375, and Targeted Storm Hardening Report Benchmark Survey and Best Practices Preliminary Draft Report, which will be filed under Project Number 36375 no later than Friday, June 26, 2009. Interested parties may file written comments on these reports under Project Number 36375 by Wednesday, July 1, 2009.

Ten days prior to the workshop the commission shall make available in Central Records under Project Number 36375 an agenda for the format of the workshop.

Questions concerning the workshop or this notice should be referred to Regina Chapline, Infrastructure Policy Analyst, Infrastructure and Reliability Division at (512) 936-7392, or regina.chapline@puc.state.tx.us. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136.

TRD-200902325
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: June 10, 2009

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Texas Department of Transportation

Port Authority Advisory Committee

This is an open meeting and was posted to the Open Meetings site on June 9, 2009:

PORT AUTHORITY ADVISORY COMMITTEE

Monday, June 29, 2009, 10:00 a.m.

150 East Riverside Drive, Room 1B.1

Austin, Texas

AGENDA

1. Convene

2. Introduction of committee members and Texas Department of Transportation staff

3. Approval of minutes from the October 24, 2008 meeting (action item)

4. Discussion and development of recommendations related to the Texas Ports 2010/2011 Capital Program (action item)

5. Discussion of Texas Department of Transportation's Ports and Waterway Conference to be held September 2 - 4, 2009

6. Discussion and development of recommendations related to the American Recovery and Reinvestment Act of 2009 TIGER discretionary grant funds (action item)

7. Discussion of Texas Department of Transportation's waterborne freight study

8. Discussion of Texas Department of Transportation's 2011 research program

9. Discussion of Gulf Intracoastal Waterway issues

10. Discussion of general matters relating to port authorities and issues for future consideration

11. Adjourn

TRD-200902305

Bob Jackson
General Counsel
Texas Department of Transportation
Filed: June 9, 2009

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University of North Texas

Amendment to Notice of Invitation for Consultants to Provide Offers of Consulting Services Related to Evaluation of the Alumni Database System

Finding by President:

The President of the University of North Texas finds that the consulting services are necessary because the University of North Texas does not have the specialized experience or the staff resources available to assess and advise on the current and future database application needs, to include alternative application options, evaluation of current records management programming processes and report on the health of current alumni records and to give recommendations for improvement. The University of North Texas believes that such expert consulting services will improve efficiency and effectiveness of development staff member and allow for better data tracking and solicitation segmenting of donors providing improved donor relations.

TRD-200902324
Carrie Stoeckert
Assistant Director of PPS
University of North Texas
Filed: June 10, 2009

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University of North Texas Health Science Center at Fort Worth

Notice of Invitation for Consultants to Provide Offers of Consulting Services Related to Development of a Potential New Academic Degree Program

Pursuant to the provisions of the Texas Government Code, Chapter 2254, the University of North Texas Health Science Center at Fort Worth (UNTHSC) extends this invitation (Invitation) to qualified and experienced consultants interested in providing the consulting services described in this Invitation to the UNTHSC. The President and Chief Executive Officer of the UNTHSC has made a finding that the consulting services are necessary. While the UNTHSC has a substantial need for the consulting services, the UNTHSC cannot adequately perform the services with its own personnel or obtain such consulting services through a contract with another state governmental entity.

The selected consulting firm will assist the UNTHSC in developing an Academic and Business Plan for improved, expanded, and secured Undergraduate and Graduate Medical Education Opportunities for UNTSHC medical students by means of a new academic degree program accredited by the LCME (Liaison Committee on Medical Education).

Any consultant submitting an offer in response to this Invitation must provide a response to the Request for Proposals. The Request for Proposals is posted on the UNTHSC website under the Bid Opportunities Page, which can be found at http://www.hsc.unt.edu/departments/purchasing/. The following information will need to be included in the response: the Execution of Offer; HUB Subcontracting Plan; Vendor Qualifications and Pricing, which includes vendor information, qualifications, history, experience, credit rating, and project pricing; proposed project workplan; project timeline that includes a detailed list of tasks and due dates; proposed staffing who will be assigned to the project; and a description of all project deliverables.

An award will be made by the process indicated in the UNTHSC Request for Proposals. The UNTHSC will: (1) base its choice on demonstrated competence, knowledge, and qualifications and on the reasonableness of the proposed fee for the services; and (2) if other considerations are equal, give preference to a consultant firm whose principal place of business is in the state or who will manage the consulting contract wholly from an office in the state.

The consulting services do not relate to services previously provided to UNTHSC.

The individual to be contacted with an offer to provide such consulting or to obtain a copy of the Request for Proposals for the consulting services identified in this Invitation is: Carolyn Cross, Associate Director of Purchasing, University of North Texas Health Science Center at Fort Worth, 3500 Camp Bowie Boulevard, Fort Worth, Texas 76107; or email cacross@hsc.unt.edu. Offers must be submitted in accordance with the posted Request for Proposals.

The proposal submission deadline will be: 2:00 p.m., July 3, 2009.

TRD-200902273
Carolyn Cross
Associate Director of Purchasing
University of North Texas Health Science Center at Fort Worth
Filed: June 5, 2009

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Texas Water Development Board

Applications Received

Pursuant to the Texas Water Code, §6.195, the Texas Water Development Board provides notice of the following applications received by the Board:

City of Wilson, P.O. Box 22, Wilson, Texas 79381, received November 2008 for financial assistance in the amount of $1,705,000 from the Clean Water State Revolving Fund - Disadvantaged Communities Program.

City of Del Rio, 109 W. Broadway, Del Rio, Texas 78840, received April 30, 2009 for financial assistance in the amount of $10,000,000 from the Drinking Water State Revolving Fund - Disadvantaged Community Program.

McCoy Water Supply Corporation, P.O. Box 1683, Three Rivers, Texas 78701, received February 2009 for financial assistance in the amount of $2,155,000 from the Rural Water Assistance Fund.

City of Vernon, 1725 Wilbarger Street, Vernon, Texas 76384-4741, received March 12, 2009 for financial assistance in the amount of $3,175,000 from the Texas Water Development Fund.

Mountain Peak Special Utility District, 5671 Waterworks Road, Midlothian, Texas 76065, received February 13, 2009 for financial assistance in the amount of $1,500,000 from the Texas Water Development Fund.

TRD-200902321
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Filed: June 10, 2009

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Change Notice - Request for Proposals for the Analysis of Groundwater Quality Samples in Fiscal Year 2010

In the June 5, 2009, issue of the *Texas Register* (34 TexReg 3564), the Texas Water Development Board posted a Request for Proposals for the Analysis of Groundwater Quality Samples in Fiscal Year 2010 (TRD-200902054). The June 5, 2009 solicitation advertised a Deadline for Submission of Request for Proposals of 12:00 p.m. - June 19, 2009.

To comply with all applicable procurement rules and regulations, the Deadline for Submission will be extended beyond the original June 19, 2009 deadline. Specific details regarding the deadline extension are available at the Texas Water Development Board web site at http://www.twdb.state.tx.us/publications/requestforproposals/requestforproposals_index.asp.

Parties interested in additional information may also contact Mr. David Carter or Ms. Tina Newstrom at facsimile (512) 475-3009 or by e-mail to david.carter@twdb.state.tx.us or tina.newstrom@twdb.state.tx.us.

TRD-200902315
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Filed: June 10, 2009

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Public Hearing Notice for Drinking Water State Revolving Fund Intended Use Plan for American Recovery and Reinvestment Act of 2009

The Texas Water Development Board (TWDB or Board) will conduct a public hearing on the draft American Recovery and Reinvestment Act of 2009 (ARRA) Drinking Water State Revolving Fund (DWSRF) Intended Use Plan (IUP) to implement funding under the ARRA special DWSRF capitalization grant. The hearing will begin at 1:30 p.m. on July 10, 2009, in Room 170 of the Stephen F. Austin Building at 1700 N. Congress Avenue, Austin, Texas 78701. Public access to the Stephen F. Austin Building is located at the Congress Avenue (east) entrance of the building.

The ARRA DWSRF IUP a list of water projects in prioritized order which will be considered for funding in Fiscal Year 2010 through the DWSRF loan program. The draft ARRA DWSRF IUP has been prepared pursuant to rules adopted by the Texas Water Development Board in 31 Texas Administrative Code Chapter 371. Please note that these rules have been waived or modified by the TWDB in certain respects in order to comply with special requirements for the ARRA DWSRF capitalization grant. The ARRA DWSRF funds must be used to fund projects that are either under construction or fully committed to construction contracts no later than February 17, 2010. Accordingly, the projects are prioritized on the basis of readiness to proceed to construction before that date. ARRA also requires that 20% of the available funds are set aside for "green" projects and 50% for deep subsidization of projects which the Board has reserved for disadvantaged communities. See the TWDB website at *www.twdb.state.tx.us/stimulus* for descriptions of green projects. Interested persons are encouraged to attend the hearing and to present relevant and material comments concerning the draft ARRA DWSRF IUP. The Board also will receive information from applicants in addition to that previously provided in order to supplement or clarify a project's readiness to proceed, disadvantaged community status, or qualifications as a "green" project. **However, the Board will not consider any changes or modifications to the scope of work for any project.** In addition, persons may submit written comments to General Counsel, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711, or may file comments at *rulescomments@twdb.state.tx.us.* **Comments and supplemental information provided outside of electronic submission at the address stated, written comments to the Board's General Counsel, or at the public hearing on July 10, 2009, will not be considered. Any comments and supplemental information received after 5:00 p.m. July 13, 2009, will not be considered.** Interested persons also may review the draft ARRA of 2009 DWSRF IUP at the Board's website at: *www.twdb.state.tx.us/stimulus/index.htm.* Copies of the draft ARRA DWSRF IUP also may be obtained in Room 560 on the 5th floor of the Stephen F. Austin Building or may be obtained from the Texas Water Development Board, Project Finance, P.O. Box 13231, Austin, Texas 78711.

The hearing will be conducted in a manner that allows all members of the public to speak. Please note that time limits on public comments may be imposed. Persons with disabilities who plan to attend this meeting and who may need auxiliary aids or services such as interpreters for persons who are deaf or hearing impaired, readers, large print or Braille, are requested to contact Leslie Anderson at (512) 463-7855 two working days prior to the meeting so that appropriate arrangements can be made.

TRD-200902298
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Filed: June 9, 2009

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How to Use the Texas Register

Information Available: The 14 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules- sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Transferred Rules- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Review of Agency Rules - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 33 (2008) is cited
as follows: 33 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "33 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 33 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online through the Internet. The address is: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the Internet. For website subscription information, call the Texas Register at (512) 463-5561.

Texas Administrative Code

The ***Texas Administrative Code (TAC***) is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac. The following companies also provide complete copies of the TAC: Lexis-Nexis (800-356-6548), and West Publishing Company (800-328-9352).

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Table of TAC Titles Affected***. The table is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register***. If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with one or more ***Texas Register*** page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
Part I. Texas Department of Human Services
40 TAC §3.704.....950, 1820

The ***Table of TAC Titles Affected*** is cumulative for each volume of the ***Texas Register*** (calendar year).